

Reflecting on Cosmetic Surgery: Body Image, Shame and Narcissism

By

Jane Megan Northrop B.N, B.A (Hons).

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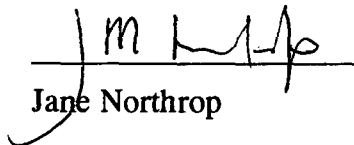
**School of Sociology and Social Work
University of Tasmania.**

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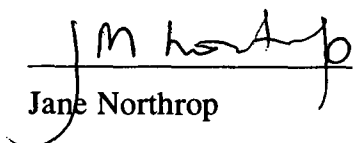
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Abstract

Cosmetic surgery is an extreme form of modern grooming. Its growth and progressive normalisation has been paralleled by increased interest, and frequent alarm, from within the academy. Social historians have located cosmetic surgery's ascendancy within the technological trajectory of medicine, set against a social world fascinated with appearance. Feminists have argued cosmetic surgery is a tool of patriarchy which oppresses and subjugates women, while sociologists have examined cosmetic surgery as a medical discourse and a form of consumption. This study took a grounded approach to engage thirty women through in-depth interview to explore how they chose cosmetic surgery as an option. Their accounts frame a theoretical discussion which proposes cosmetic surgery is initiated within the vulnerable and divisive relationship between the self and its poor body image. Participants dismissed the widely held belief that media is to be blamed for distorting the relationship women have to their appearance, choosing instead to locate the source of their discontent much closer to home. Following the work of the psychoanalyst, Paul Schilder (1950), and the sociologist, Charles Horton Cooley (1962), body image is interpreted as an ongoing process constructed in social interaction with significant others. This study examined the way in which these interactions contribute to poor body image. Poor body image and the attempt at its reparation are examined conceptually through shame and narcissism to expand upon a sociological understanding of body image and its relationship to cosmetic surgery. By engaging data and theorists from multiple disciplines this study found that shame constitutes a framework within which we formulate appearance norms and learn the art of becoming socially embodied. Shame exposes the material body and the ways in which we manage its margins. Shame concerns the self, but it arises in response to perceived social phenomena. Through the evaluation and amendment of body image with cosmetic surgery, notions of self and social worthiness are played out. As this study progressed, the relationship between shame and narcissism emerged as increasingly significant. This study concludes by arguing for a review of the way in which we understand narcissism and proposes that shame is directly implicated in its manifestation.

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Introduction

Whenever a woman is asked why she has had cosmetic surgery her short answer is very likely to be “I didn’t like the way I looked and I wanted to look better for myself.” To many people such a response is reasonable enough to not warrant a great deal of further discussion. In a cultural climate where the vast majority of women are less than happy with their appearances, “wanting to look better” barely raises an eyebrow. Indeed, finding women who are entirely happy with their appearance is more unusual. Such women are becoming an anomaly; a minority group who could technically be described as deviant, and to whom other women look with a kind of wonder and, quite possibly, respect. Such women are extraordinarily fortunate since being content with one’s appearance inevitably frees up time, energy and money which can be directed elsewhere. While women who have cosmetic surgery want to change their appearance they are also aspiring to join that small group of women who are happy with their appearance. They want, more than anything, to be able to look in the mirror and to be happy with what they see.

Not insignificantly, as body image dissatisfaction in women approaches the level of norm, body image anxiety has surfaced as the essential variable required by grooming industries like cosmetic surgery to succeed. Moreover, it is to this vast discontent that hugely profitable global organisations market an unprecedented range of grooming products and services designed to redress the problem. Media, with an unnerving and purposive agenda, accompanying us into our bedrooms, bathrooms and seemingly infiltrating our very psyches, is usually attributed blame in distorting the relationship women have with their bodies. Whilst the effects of media are undoubtedly pervasive, how media exerts its impact is far less certain. Like many others who have examined the progressive acceptance of cosmetic surgery, I assumed that tracking down the impetus behind turning to a surgical fix would uncover the role of media, magazines in particular, and of men. That was until I actually started speaking to women themselves and found that this teleological formula did not quite stack up. What I found in their long answers was an angst related to appearances born much closer to home.

This study comprised in-depth interviews with thirty women who had engaged with cosmetic surgery on some level, including twenty six who had undertaken surgery. Any suggestion that media may have encouraged them to undergo cosmetic surgery was poorly received. A few were downright insulted, while others appeared irritated or disappointed with the simplicity, or predictability, of such a proposition on my part, which not only roused their indignation but threatened the ambience of the interview. Participants did nonetheless agree that media plays an important role in disseminating information about cosmetic surgery and informing of new procedures as they become available, which, they did concede, has had a cumulative effect in normalising cosmetic surgery as a self-enhancement option.

Despite its increasing normalisation cosmetic surgery remains a substantial undertaking. Electing to have a general anesthetic, the recovery time involved and the overall risk associated with any surgery, along with the financial cost means that cosmetic surgery can never be considered as lightly as a cosmetic procedure like a shot of Botox or collagen which might be administered in a doctor's surgery or specialist clinic during a workday lunch break. Choosing to have cosmetic surgery, especially on the first occasion, still represents an extreme in mainstream body modification technology. However, cosmetic surgery is, at its heart, no more than an intentional and committed grooming strategy enacted to ameliorate or improve body image and, as the interviews for this study proceeded, I began to realise that the real opportunity this study availed was not solely to explore cosmetic surgery as an event, rather, it provided an opportunity to examine the underlying body image dissatisfaction which participants undertaking cosmetic surgery overwhelmingly articulated. Pre-surgical body image dissatisfaction was expressed as a consistent theme across all interviews with varying degrees of emphasis. How this dissatisfaction emerges and is sustained to the point where cosmetic surgery becomes the only foreseeable option became a central question this study sought to explain.

It was in the participants' discussions of formative body image construction that evidence of an alignment between the appearance values held by their parents and those espoused in media was observed. Learning to inhabit the body and become socially embodied comprises the earliest of formative learning, and findings from this study suggest that when those

closest to participants shared the same appearance values as those espoused in media, and afford them particular emphasis, formative body image construction is likely to be impacted. The participants confirmed their awareness of mediated fashions surrounding the body, particularly those which connote social success, and these did correlate to the ideals their parents and significant others admired during formative and impressionable periods of body image construction. Furthermore, it was through intimate familial interactions that those ideals were communicated, in both subtle and overt ways, and then inadvertently woven into the seminal experience of formulating body image. Whether a participant fell short of approximating an appearance 'ideal,' or not, was identified by many participants as something a parent had initially drawn their attention to. A failure to meet the ideal admired by a significant other was further compounded by the perceived sense of ineptitude in meeting the very same ideal adorning the screens, billboards and magazines to which the modern eye is consistently drawn. Formulating body image under associated constraints emanating from both the intimate and socio-cultural spheres makes it inordinately difficult for any girl, teen or woman to ever feel content in her own skin. Furthermore, poor body image was observed to be directly implicated in the consumption of grooming products and services, of which cosmetic surgery represents the newest alternative.

The bodies of women are socially and libidinally significant to themselves and to the world in which they engage. How a woman appears has always had a bearing on how she will be evaluated and received in the social world and, because of this, many women learn to evaluate themselves in the same ways they imagine others will judge them. This study found that women who reject their body image and seek its amendment with cosmetic surgery have often experienced the rejection of their bodies by others, whether literally or intuitively, in an intimate setting. Focusing on the contexts and interactions associated with the initial foray into cosmetic surgery in particular exposed a specific episode of heightened body image dissatisfaction and women participating in this study accounted for their surgeries across an arc of self-improvement strategies. At one extreme initiating cosmetic surgery was articulated with an uncomplicated pragmatism, which stood in contrast to an opposing narrative that bestowed upon cosmetic surgery a therapeutic function. Moreover, those participants who had mobilised cosmetic surgery as therapy sought not only bodily

amendment, but self-amendment through improved body image. Over half the participants in this study appeared to have a conflicted relationship with their appearance that had emerged in early childhood or adolescence, while the remainder described dissatisfaction with their appearance arising in adulthood as they aged, lost or gained weight, or following pregnancies. This project focuses much of its attention on the experiences of the former group, and thus does not attempt to provide an overarching explanation which can be applied to all women who undertake cosmetic surgery. Rather, it contains its ambitions to exploring the most complex accounts presented by those who took part in this study.

These findings evolved from thirty in-depth interviews with women on the subject of cosmetic surgery. I was interested to know what had shaped their decisions to have cosmetic surgery: how it came to be seen as an option, who had supported them in their decisions to proceed with surgery and how having cosmetic surgery had affected their lives. A general question asking participants if appearances had been an important issue in their lives when they were growing up produced a wide range of discussions, many of which were unforeseen and confronting. Twenty six women of those interviewed had undertaken cosmetic surgery within ten years of being interviewed, another two were booked to have surgery and two additional women were interviewed because of their expressed interest in the subject of cosmetic surgery. Their interviews offer eloquence and insight into questions of ageing, gender and the work setting. Prior to undertaking interviewing, I reviewed literature on cosmetic surgery and found that few qualitative researchers had actually engaged with women who had undergone cosmetic surgery. This study is aimed at adding to and developing an understanding of the circumstances under which women engage cosmetic surgery.

Chapter One looks to the academic literature on appearance and the history of cosmetic surgery to examine the convergence of social conditions and disciplinary advances which have seen cosmetic surgery flourish. It draws upon the work of the social historians Sander Gilman (1999) and Elizabeth Haiken (1995) who both direct their attention to the history of cosmetic surgery. Chapter Two considers the relationship between women and their appearance and reviews the contributions made by selected feminist scholars toward

understanding women's engagement with cosmetic surgery. Insights gleaned from the authors discussed in these chapters enabled me to orientate my own study by identifying gaps in the work already done.

Methodologically my approach borrowed from grounded theory (Corbin and Strauss 1990). As there had been limited qualitative studies done when I began this project it made sense to begin inductively. Such an approach engages participant contributions in formulating the direction which the study takes, facilitating the emergence of observable concepts from data itself. I approached each interview with a basic theme list but the interviews themselves were intended to be conversational. Participants were offered either the opportunity to tell their story or, if they preferred, for me to ask questions. These questions were initially general, enquiring about the types of surgery that had been undertaken and whether or not the participants had been happy with the results. As the interviews proceeded and participants themselves added their own layers of information, additional themes emerged which were worthy of exploration and introduction to subsequent interviews.

Early analysis of the interviews directed my attention to the notion of body image itself. It became increasingly apparent that when participants spoke of improving their appearance with cosmetic surgery they were not actually speaking about their bodies; rather, they were referring to body image, their own subjective experience of perceiving how their bodies appeared. This may seem somewhat self-evident but body image is a complex phenomenon involving individual perception and emotional experience. Furthermore, asking participants how they felt about their appearance had been something of a conversation stopper, whereas asking participants how they felt when they had looked at themselves in the mirror prior to having surgery did stimulate discussion.

Taking these observations from the interviews, I then directed my theoretical attention to understanding the role that mirrors play in body image construction and its evaluation in the lead up to cosmetic surgery in Chapter Three. Drawing upon the work of Paul Schilder (1950), Jacques Lacan (1977) and Charles Horton Cooley (1927, 1962, 1964) I found myself questioning whether the poor body image evaluation many participants were articulating was,

as Cooley (1964) suggests, related to shame. I reanalysed participant accounts to explore this possibility and was re-directed back to the texts to broaden my understanding of shame in relation to body image. Cooley (1964) introduces shame but does not develop it conceptually.

The work of Norbert Elias (1978) proved insightful on the question of shame, as is discussed in Chapter Four. His reading of shame is sociological, historical and demographic. Elias describes shame as the human denial of our animalistic attributes encapsulated in the progressive distancing of human social life from the natural world. He nominates these processes as broadly cultural and social, but reproduced and reiterated through childhood socialisation. Elias takes as given that the modern relationship between self and body is one increasingly imbued with a specific form of anxiety which he nominates as shame. Shame, he contends, has emerged from the fear of social exclusion which failed mastery of the body almost surely elicits. However, Elias' interest lies in the broader social dynamic. He considers gender only in passing and any detailed understanding of the subjective experience of shame is absent from his work.

In an effort to develop a theoretical understanding of the subjective experience of shame I turned to the work of psychotherapist and psychoanalyst Helen Block Lewis (1971) as described in Chapter Five. Lewis' work dovetails with Elias' as she unpacks formative socialisation and its role in the development of shame. Her theoretical insights resonated with the experiences of those observed in this study but perhaps more importantly, my engagement with her work facilitated the negotiation of the more difficult events participants disclosed about their formative lives and how these had subsequently impacted their constructions of body image. Moreover, participant accounts suggest that those who encountered their formative body image as flawed went on to experience ongoing problems with body image construction. Significantly, those who developed poor body image in childhood appeared to struggle with poor body image well into their adult lives. They were consistent consumers of grooming products and services and tended to have the most cosmetic surgeries. Chapter Six explores how participants accounted for their poor body image in relation to their childhood experience. The most pronounced accounts of body

image anxiety describe shame events in childhood. These participants' attempts to construct body image were the most complex and their self concepts' the most fragile. Their discussions of bodily loathing underlined a distinct rift between self-conceptualisation and body image. Furthermore, findings from this study suggest that those who grew up experiencing their body image as something shameful were more likely to continue having poor body image as adults. Such a finding raises the possibility that developing poor body image in childhood potentially habituates women to a life-long consumption of specialist grooming products and services.

Chapter Seven continues with the theme of shame but shifts focus from recalled early socialisation to adult experience. This chapter utilises the voices of participants to explore the way in which particular contexts, nominated by the participants themselves, expose the conceptual relevance of shame to the enactment of cosmetic surgery. Thematically, the most significant contexts relate to particular interactions with partners, the social integration of the post-surgical body and the encounter with cosmetic surgeons themselves. The last section in this chapter considers the way in which participants discussed cosmetic surgery in relation to their participation in the workforce. In these discussions participants spoke of cosmetic surgery as a strategy to ameliorate the gendered constraint of ageism which they identified as a significant feature within the workplace. They described their workplaces as competitive and felt that their roles were threatened by stereotypical assessments which assumed that because they were female and older they had ceased to be competent in their professional roles. Their discussions reveal the ways that women can experience body image, as something tenuous, which is vulnerable to the poor evaluations of others and is therefore potentially shameful. In these cases cosmetic surgery was engaged as a pre-emptive act of impression management to avert a loss of status, or to secure the confidence of others with an overall view to maintaining professional viability in the workforce. Their accounts demonstrate that women perceive their appearance to be a more significant feature of their overall social capital than is the case for men and, despite women's advances in the arena of paid work, their participation within the workforce is subject to a much harsher set of constraints than those faced by men.

The final chapter of this study presents an exploratory discussion on the highly contested theme of narcissism. Narcissism emerged, somewhat irrepressibly I might add, throughout the course of this study as a concept directly implicated in the amendment of shame. From the time of Ovid's (1997, 2004) poem Narcissus has generated ongoing fascination but the role of shame in Narcissus' death has not been adequately recognised. Narcissus' quest for the love of another is often misread as fatal self-absorption but, I argue, woven into the lines of Ovid's well thought-out poem is a sophisticated discussion on the peril of unresolved shame. Moreover, Ovid illustrates through the role of Echo a model for hearing and acknowledging narratives of suffering which include those related to shame. In the end, I give the last word to Echo and suggest, in the attempt to understand shame, we must firstly accept shame's role in the ongoing relationship between socialisation and embodiment. Furthermore, we must be prepared to hear stories of shame. For them to remain hidden sustains our collective denial of shame's presence, which, as Ovid make clear, can have dire consequences.

The relationship between shame and narcissism has been identified from within the small group of psychoanalysts who have made shame the central focus of their studies (see for example Lewis 1986, Morrison 1989, Wurmser 1987), but the congruence between shame and narcissism has not received widespread recognition. It would appear that part of the difficulty in establishing the link between shame and narcissism stems from the tendency within psychoanalysis and psychology to limit the view of narcissism to clinical pathology, which has inhibited the possibility of understanding narcissism as normative behaviour. Chapter Eight explores how the term "narcissism" has come to be used in the modern sense and argues that alongside the pathological version of narcissism there is a need to acknowledge a normative form which is manifested in the response to shame. Shame, this study found, has a restitutive agenda. Those who experience shame seek to correct their shameful attributes in the attempt or restore self-love and, therefore, social acceptability.

Collectively agreed upon shame structures frame the management of the body and impact upon self-perception. Shame informs appearance norms and through ongoing socialisation constitutes the way in which the self learns to become socially embodied. Shame structures

the terms under which the body is permitted to inhabit the social world. It demarcates and maps its boundaries, and determines which bodies are permitted access to privileged social domains. Shame directly concerns the self but it is manifested in response to perceived social phenomena. Moreover, the poor body image participants in this study reported suggests poor body image is unequivocally implicated in the experience of shame. Body image represents a component of self-perception but poor body image readily infuses the entire self with a sense of its own unworthiness, with shame. Poor body image and the measures women take to address it are, I contend, embedded within a dynamic which links shame and narcissism to its subsequent amendment. However, the amendment strategies employed by those with poor body image are frequently dismissed, or shamefully labeled as vain or narcissistic. To dismiss such women and their concerns relating to body image is to forfeit the opportunity to explore shame and add to our understanding of narcissism. More importantly, to dismiss the significance of body image in the lives of women is to imperil those we love: our daughters, our mothers, our sisters and our friends. This project evolved from the accounts of those who took part in this study, but their concerns about body image were not rare or unusual. In a cultural climate which places a premium on appearance, and the appearance of women in particular, body image, and the way in which it is experienced, should be of concern to us all.

Chapter One: Evolving Appearance Norms and Cosmetic Surgery

Cosmetic surgery is one of the fastest growing and most lucrative of medical specialties (Haiken 1995, Sullivan 2000). This chapter considers the historical and social settings and trends that have evolved to provide such an extraordinarily fecund cultural climate in which the practice of cosmetic surgery appears to thrive. Demand for cosmetic surgery has arisen from within a particular set of social matrices developing over several centuries. This chapter draws on the work of sociologists and social historians to identify these processes and to argue that bodily appearance has persistently been used in systematic ways to organise and classify particular social groups. The early history of cosmetic surgery was instrumental in refashioning features of physical appearance which were collectively deemed to be stigmatising, but its more recent emergence as a major grooming industry has seen it take an increasing role in determining the parameters of physiological appearance, in particular the appearance of women. Despite the apparent growth of the cosmetic surgery industry, determining its actual size relies on estimation. Cosmetic surgery is sanctioned by institutional medicine but functions largely outside its structures; consequently, it is difficult to ascertain the extent of the industry with any accuracy. This chapter begins by providing a brief overview of the recent growth in the cosmetic surgery industry, before considering the social and historical underpinnings of the industry's formative development. This overview is based on the Cosmetic Surgery Report (CSR) undertaken by the Health Care Complaints Commission of NSW (HCCC) in 1999, and the most recent statistics provided by the American Society of Plastic Surgeons (ASPS 2007).

The CSR (Walton 1999) examined the cosmetic surgery industry in NSW and found that the way service providers delivered their services left consumers vulnerable and was far from ideal. The CSR defined cosmetic surgery as a surgical procedure undertaken to 'reshape normal structures of the body, or to adorn the body, with the aim of improving the consumers' appearance and self-esteem' (Walton 1999: v). It observed that consumers themselves initiate treatments with the aim of improving their appearance and promoting self-esteem. It also acknowledged that their judgments about their appearances were

subjective. With regard to service delivery the CSR found that there was a great deal of variation in the training of those who practise cosmetic surgery.

The Fellows of the Royal College of Surgeons (FRACS) requires surgeons who practise in public and most private hospitals to have undergone six years of specialised post-graduate training and successfully passed two exams. However, a basic medical degree completed in Australia comprises two undergraduate degrees: a Bachelor in Medicine and a Bachelor of Surgery. Therefore any doctor who is registered as a medical practitioner can call himself a surgeon and practise cosmetic surgery (Walton 1999:34). A broad range of medical practitioners, including those specifically trained to practise reconstructive, plastic and cosmetic surgery, dermatologists, ophthalmologists, ear, nose and throat specialists, as well as general practitioners, are among those who currently perform cosmetic surgery and cosmetic procedures. In addition, nurses, under the supervision of medical practitioners, perform cosmetic procedures such as injecting collagen, laser treatments, dermabrasion and facial peels. To a lesser degree dentists too carry out cosmetic procedures. Furthermore, the cosmetic surgery industry currently functions outside the regulated framework of organised medicine and consequently offers few safeguards to consumers (Walton 1999: v). Most cosmetic surgery is performed in private hospitals, day surgery units or doctors' rooms. Recent developments in local anesthesia, nerve blocks and sedation have reduced the need for general anesthesia, resulting in an increasing number of cosmetic procedures such as laser skin resurfacing and liposuction being performed in doctors' rooms. This shift to doctors' rooms is not unique to cosmetic surgery as the development of less invasive techniques has facilitated a more general trend which has seen surgical procedures once done in a clinical setting increasingly being done in doctors' rooms (Walton 1999:29).

This shift from an institution setting to private rooms often reduces the costs to consumers, but it has also diminished the protections otherwise available to them. Consumers are exposed to further potential risk since doctors performing cosmetic procedures are not answerable to a particular professional organisation, nor are they required to undergo specific training. They are not required to demonstrate competency and, away from larger clinical settings, safety issues are no longer subject to regulation or peer review. In addition, while

Medicare may cover some cosmetic surgeries, consumers can also self-refer without prior consultation or referral by a GP. Therefore the relationship between patient and cosmetic surgeon is potentially exclusive. This is of concern because the clients themselves may already be vulnerable, and they may be dealing with doctors whose skills are questionable who operate outside established structures, which leaves them potentially exposed. One cosmetic surgeon I spoke to during the course of this study said he understood why cosmetic surgeons had such a poor reputation since many of those performing cosmetic surgery were shysters and not far removed from used car salesmen.

When the CSR presented its findings in 1999 it was not known how many people were undertaking cosmetic surgery but it was estimated that one in eighty Australians had had a cosmetic procedure of some kind. In addition the HCCC commissioned a study as part of the report which found that people undertaking cosmetic surgery came from a diverse range of age, geographic and income groups. Most people surveyed had initially been informed about the cosmetic procedure they underwent by media and advertising. Just under half of the respondents reported having more than one cosmetic surgery (Walton 1999: v). The majority (over 60%) paid for their procedures from savings, 23% paid by credit card or bank loan and 7% were gifted money for their surgery. One quarter had procedures covered in part or full payment by private health insurance funds and a similar number claimed payment through Medicare. Costs may be covered by Medicare if procedures are determined to have been done for therapeutic reasons (Walton 1999:13). Despite its inherent limitations in gauging the extent of the cosmetic surgery industry in Australia the CSR provides some insights into the problems existing within the cosmetic surgery industry which persist today, particularly in relation to regulating the competency of practitioners and the provision of safeguards to prospective clients.

The American Society of Plastic Surgeons (ASPS) first formed in 1931, and is now the largest organisation representing certified physicians, plastic and reconstructive surgeons in the world. Their webpage, www.plasticsurgery.org, lists the surgeries and procedures their members have been performing since 1992 and provides an indication of the trends and fashions in cosmetic surgery. Statistics for the period 1992-2007 show that the number of

Americans having cosmetic surgery performed by their members has almost quadrupled (ASPS 2008:15). During this period their members alone performed cosmetic surgery or a cosmetic procedure on twelve million Americans who spent almost twelve and a half billion dollars for their services. Nearly ten million of these cases were minimally-invasive procedures and close to two million were cosmetic surgeries (ASPS 2008:3). In 1992 when the ASPS first started monitoring what their members were doing the most frequently sought surgery was an eyelid lift. Over the period from 1992 to 2007 the number of people having eyelid surgery more than quadrupled, but the most phenomenal increase was in the number of women having breast augmentation (ASPS 2008:15).

In 2007 the most highly sought surgery was breast enlargement (327,524 women) which represented more than a tenfold increase since 1992. The next most popular surgery was liposuction. While women sought surgery to their bodies by having their breasts enlarged and their bodies effaced with liposuction, men sought surgery to have their noses reshaped and their eyelids lifted. However, with 91% (ASPS 2008:5) of those seeking cosmetic surgery being women, cosmetic surgery remains an emphatically feminine pursuit. Significantly, 42% of those seeking a cosmetic procedure, either surgical or minimally invasive, were repeat patients, and 42% of all patients had several procedures done at one time (ASPS 2008:13). The most prolific seekers of cosmetic surgery were aged 40-54 years (33% of all those having cosmetic surgery) where liposuction, followed by eyelid surgery, was the most highly sought surgery (ASPS 2008:10). Any figures from the ASPS must be considered only a part of the whole picture since the actual number of people undertaking cosmetic surgery in the United States is impossible to gauge, much as it is in Australia, because a range of medical practitioners not registered by the ASPS practice cosmetic surgery. Nevertheless, it is clear from the ASPS statistics that cosmetic surgery is big business and those who have one procedure are likely to go back for more.

Social to surgical bodies

The appearance of the body has always been socially significant. While there can be little doubt that the unadorned body is already a social body, inscribed for example by age, gender, pregnancy, illness and access to nutrition, the overlaying of grooming interventions upon its

exterior reiterates the body as a social object. Moreover, modifying the appearance of the body has been an integral part of the cultural practice of all social groups throughout history.

Physical appearances are primary sources of information which convey and guide social interactions. Mauss (1973) and later Douglas (1973) proposed that bodily inscriptions, dress, adornment, racial features, posture and gait were complex symbolic systems which could be interpreted as taxonomies that subsequently disclosed social groupings. They proposed that the body could be read as an artifact, inscribed by cultural practice and imbued with meanings suggestive of broader social mechanisms and processes. In 'Techniques of the Body' Mauss (1973) argued that all aspects of corporeal function are learned, rather than something which simply occurs as a result of natural behaviour. He reviewed a diverse range of corporeal functions and observed variation between societies, but also found differences within subgroups which were dependant on variables such as class, status, education and fashion. Mauss (1973:73) emphasised that 'the art of using the human body' was something learned through socialisation, but contended that children will take their leads from significant others who demonstrate confidence and authority. He suggests that children do not merely imitate those around them but choose to model the way they use their bodies on those who appear to be the most socially successful. Mauss (1973:73) describes the process as 'prestigious imitation.' Body techniques can therefore be interpreted as consciously assembled symbolic systems constructed in accordance with dominant social authority. Significantly, Mauss also concedes that fully understanding these processes cannot be achieved by sociological endeavour alone and calls for a tripartite approach which incorporates physiology and psychology. He claims that socialisation processes integrate social elements, but the imitative dimension within socialisation requires engaging psychology and physiology to acquire a fuller understanding of the way in which body techniques are subsequently adopted.

Douglas (1987:93), following Mauss, uses the metaphor of two bodies, the physical body or the self, and the social body to elaborate a more fluid, interactive, but ultimately limited corporeal relationship between the social group and the individual:

The social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meanings between the two kinds of bodily experiences so that each reinforces the categories of the other. As a result of this interaction the body itself is a highly restricted medium of expression.

Goffman (1969) adds to the discussion, drawing attention to individual agency and highlighting the ways in which available body techniques are used as a repertoire from which individuals choose to construct a performative social identity in the attempt to exercise some control over how others perceive them. Frank, however, argues, 'Body techniques are socially given - individuals may improvise on them but rarely make up any for themselves ... These techniques are as much resources *for* bodies as they are constraints *on* them; constraints enable as much as they constrict'(1991:48, original emphasis).

When considering a sociological examination of the body three themes come into focus: firstly, the way in which the body is constructed socially and culturally, secondly, the way in which social control and the regulation of bodies is enacted and, thirdly, the way in which these themes relate to, and inform, self-surveillance. The last theme cannot evade the psychosocial dimension of embodiment, as suggested above, and these psychosocial aspects will be considered in Chapter Three. The remainder of this chapter will address the first two of these themes, examining the way in which appearance norms have evolved and how they have impacted upon the development of a burgeoning cosmetic surgery industry. To understand why cosmetic surgery is being embraced increasingly as an optional 'body technique,' it is useful to consider the way in which these themes might be understood within the context of the historical development of the specialty.

The arrival of modernity and the ensuing social differentiation it inaugurated, as well as the globalisation of mediated images, meant individuals began to rely increasingly upon systematic classification to establish a perceptual ordering of their expanding social worlds. Classification functions as a form of visual shorthand required to interpret and process the

vast array of visual data that individuals are exposed to on a daily basis. Visual literacy has become integral to informing the construction of personal identity, to the way in which we cognitively understand the world around us, and in defining and controlling social groups (Douglas 1987:100). Classificatory systems delineate groups on the basis of characteristics such as gender, class and race, where inclusive membership is defined in opposition to “otherness.” Gilman (1999:22) claims that physical categories are increasingly constructed in ‘unambiguous antithesis’ (for example: young and old, fat and thin, black and white etc.) where dichotomous value attributes advantage to belonging to a positive category and disadvantage to belonging to a negative category. Values attached to physical appearance are far from universal and vary from culture to culture. Nor are they temporally or spatially static. What has been deemed to be a fashionably desirable figure has fluctuated historically. However, one characteristic in the way we read bodies to have seemingly endured is the omnipresent belief that external appearance accurately reflects the character, the soul or the inner self. Such beliefs can be traced back to antiquity (Finkelstein 1991, Gilman 1999).

Modern cosmetic surgery emerged in Europe during the 1890s at a time when the “science” of physiognomy enjoyed widespread popularity. Physiognomy deemed that facial features reflected the innermost character of the individual and represented a mirror to the underlying self or soul (Finkelstein 1991, Gilman 1999). Physiognomy has a long history dating back to *De Physiognomia*, written by Aristotle in the third century BC. Here physical appearances were classified by resemblance to animals and human character itself was accorded the nature of the corresponding animal. Subsequent texts, written in a range of languages over the centuries to follow, reworked these themes, at times combining astrology and palmistry to create theoretical frameworks which formulated predictions and provided templates to interpret health and character. The evident proliferation of texts is significant testimony to the enduring fascination of physiognomy (Finkelstein 1991). The face, usually visualised and accessible, became the conveyer of symbolic meaning imbued with moral significance. In its most simplistic form beauty reflected goodness and ugliness warned of a bad character. A ‘behavioural determinism’ which ‘foretold and reflected the moral characteristics of the individual’ (Finkelstein 1991:23, 24) underpinned the beliefs of the physiognomists. Such was their authority that prominent eighteenth century advocate Johann Lavatar, and a century

later Cesare Lombroso, detailed the facial characteristics of criminal types and proposed they be identified and tattooed to prevent them embarking on criminal careers (Gilman 1999:27). The beliefs of the physiognomists were remarkably pervasive and long maintained a level of cultural currency. Indeed, as Goffman (quoted in Finklestein 1991:50) could write, 'the person who falls short' of 'certain moral, mental and physiognomic standards is forced into secondary status.'

Technological advances in anesthesia and asepsis in the late eighteenth century minimised surgical pain and the risk of infection, making the option of surgery much more accessible to those contemplating cosmetic surgical alteration. Moreover, with the beliefs of the physiognomists so entrenched, enhancing ones features was always going to appeal to those who felt marginalised by their appearance. However, these developments alone were not enough to initiate the emergence of modern cosmetic surgery. Gilman (1999:18-19) posits that the ideology of individualism, autonomy and self-transformation in the pursuit of happiness which the Enlightenment platform proclaimed, and the Enlightenment motto "Dare to use your own reason" underpin the acceptance and subsequent growth of cultural bodily practices such as cosmetic surgery. Happiness and the fulfillment of patient desires, claims Gilman (1999:18, 19), are the underlying thesis upon which aesthetic surgical practice is based. Here group membership based on physical attributes is considered central to personal happiness.

Gilman proposes the model of "passing" as a theoretical tool which explains the historical development of what he describes as aesthetic surgery, providing insight into the motivations of those who undertake it.

The pursuit of happiness through aesthetic surgery presupposes categories of inclusion and exclusion. Happiness in this instance exists in crossing the boundary separating one category from another. It is rooted in the necessary creation of arbitrary demarcations between the perceived reality of the self and the ideal category into which one desires to move. It is the frustration or fulfillment of this desire that constitutes "unhappiness" or "happiness." (Gilman 1999:21, 22)

It is important to note that other attributes such as a distinctive accent may also suggest exclusion and “otherness,” but for the most part, outward signs are indicative of physical differentiation.

Passing involves not only moving from a perceived negative to a positive category when visualised appearance is transformed, but also implies that the moral meanings of character associated with physical appearance will likewise be transformed. Patients seeking surgical alteration perceive that their exclusion from a desired category and inability to “pass” are determined by their physical appearance, which thus is the cause of ‘psychological “unhappiness”’ (Gilman 1999:1922). Here cosmetic surgery is not undertaken to stand out in a crowd; rather it is undertaken to move into a desired social group and to become invisible within that group. Indeed, the success of the surgeon is measured by the patient’s authenticity post-surgery, measured by the ease with which the surgically altered individual is able to pass unnoticed into a desired group (Gilman 1999:22-26).

Passing can be understood as an individualised response ‘to our persistent and constant need to generate stereotypes in order to organize the world’ in which we live (Gilman 1999:330). Aesthetic surgery relieves the fear of being placed in a visually determined stereotypical category which is seen as undesirable. It alleviates anxieties about belonging and not belonging to a desired social group and affords the individual some sense of control, however illusionary, over his or her immediate life world by altering a particular aspect of their body. Cosmetic surgeons then become ‘agents’ to those desiring surgery, enlisted to help them establish agency over their bodies and realise the idealised notions of the bodies they desire (Gilman 1999:331, 332).

In the nineteenth century the most difficult feature to hide and disguise, the feature believed to most accurately reveal character, was the nose. Gilman (1999) takes the nose as a central symbol to argue that the Western history of aesthetic surgery is directly linked to individual desire to erase, firstly, moral markers and, later, racial signs betrayed by its shape. The earliest documented evidence of surgical reconstruction of the nose is the use of skin grafts dating back to Indian Sanskrit writings in 900 BC. There had been no system of

incarceration in India and those found guilty of crime were punished by the severing of hands, limbs or the nose. In the eighteenth century, British colonists became aware of skin grafting techniques performed by a caste of Indian brick-makers where a nose-shaped template of skin was lifted from the forehead, twisted and laid over the exposed nasal bone. Reeds were inserted to allow the flow of air and simulate nostrils.

This technique was far more sophisticated than techniques already pioneered in the West and surgeons in Europe and America quickly adopted the procedure (Gilman 1999:75-77).

Indeed, in Europe, sixteenth century surgeon Gaspare Tagliacozzi had documented his practice of taking skin from the upper, inner arm and grafting it over the nose in a painful, cumbersome and often unsuccessful procedure which required the flap, still connected to the arm and dependant on its blood supply, to remain positioned *in situ* over the nose for up to twenty days. Maintaining this position required that the patient be positioned in an elaborate frame (Gilman 1999:66, 67). Tagliacozzi, nevertheless, is widely recognised as the father of cosmetic surgery. He wrote textbooks outlining his techniques and explained his motivation to practise:

We bring back, refashion and restore to wholeness the features which nature gave but chance destroyed, not that they may charm the eye but that they may be an advantage to the living soul ... the end for which the physician is working is that the features should fulfill their offices according to nature's decree (Brown quoted in Sullivan 2000:35)

Tagliacozzi, however, was not without his critics. Rumour claimed that after his death, church leaders ordered the exhumation of his bones from a cemetery and their removal to unconsecrated ground (Gilman 1999, Sullivan 2000), a punishment deemed fit for one who dared to interfere with the will of God. His medical contemporaries derided him, copies of his book were destroyed and grafting techniques disappeared in Europe until the Indian techniques were adopted in the eighteenth century. Later innovation saw nineteenth century surgeons experiment with a range of materials to reconstruct the bridge of the nose, from metals such as gold and platinum, injections of paraffin, rubber and ivory, to the sternum of a live duck killed in the operating theatre and inserted into the nose of an anaesthetised patient

in 1892. In 1896 the first bone grafts were carried out to repair a syphilitic nose. These crude attempts succeeded in simply changing the look of the nose and camouflaging the syphilitic features with an alternative pathology; patients were thus able to pass as someone other than an individual infected by syphilis (Gilman 1999:57, 58).

Gilman traces the emergence of modern aesthetic surgery to the late sixteenth century epidemic of syphilis. Syphilitic infection erodes the cartilage and prominent nasal bone resulting in a depressed or “saddle nose” and feminised voice, feared moral markers of sexually transmitted disease. Syphilitic spirochetes readily cross the placental barrier and its stigmatising features can be congenitally transmitted to subsequent offspring, presenting in up to the seventh generation (Gilman: 1999:49-51). The depressed nasal bridge came to be read as an inscription, a public sign of corrupted moral which represented diseased and dangerous flesh. Blood testing and the early treatment with antibiotics have made cases of syphilis rare in the developed world. In contemporary Australia pregnant women are routinely tested to prevent its congenital transmission.

Progressive colonisation brought increasing contact between nations. Dutch anatomist Petrus Camper (1722-89) was the first to develop the facial angle and nasal index, which became a tool linking all human races and distinguishing them from higher primates (Gilman 1999:86-88). His successors used this system to create a hierarchy of races in which the most inferior were African. The black nose, typically broad and flat, signified essentialised notions of primitiveness, deformity, aesthetic displeasure and tarnished character. Kant, in his essay *Various Races of Mankind* (1775), illustrates the perceived linkage between character and facial aesthetics:

The growth of the spongy parts of the body must increase in hot and damp climates. Thick snub nose and sausage lips result ... The black is appropriate to his climate, that is, strong, fleshy, supple, but because of the provisions of his motherland, lazy, inactive and slow (in Gilman 1999:88)

In this hierarchy of races, dominant, desired facial features and body types were modeled on idealised forms of high art, primarily classical Greek and Roman sculptured faces, where features were symmetrical and the nose deemed well shaped. *Personal Beauty and Racial Betterment*, written in 1920 by experimental psychologist Knight Dunlap (in Haiken 1995:181), illustrates how ideas of beauty and race intersect. Dunlap defines beauty as a 'positive condition' which can only prevail if 'negative conditions' are absent. Dunlap lists 'negative conditions' as Negroid features suggestive of 'inferior race,' signs of illness or deformity and facial features which deviate from 'average.' 'Average' in Dunlap's estimation meant Caucasian. Altering the facial features which function as markers of race, or changing features to more closely conform to the dominant aesthetic ideal, enabled individuals to pass into alternative social groups and circumvent stigma processes. As one woman could note:

The less you look like a Negro, the less you have to fight. I would pass for anything so long as I'm not taken for a Negro. With a straight nose I could do costume work and pose as an Indian, Egyptian or even Balinese (Macgregor in Gilman 1999:116).

Marginalised groups have long refashioned their bodies in accordance with the appearance norms of the dominant or ruling classes in a contemporary enactment of 'prestigious imitation' (Mauss1973). A centrally important question this thesis sought to explore was whether being outside sanctioned cultural appearance norms potentially increases individual vulnerability to shame.

Social control and mass production

The making of the modern self took place in public spaces, contrived landscapes where the presentation of self became increasingly important. In France and England in the eighteenth century hierarchical dress codes relating to social location were enshrined in legislation when sumptuary laws forbade people wearing clothing which concealed their social status. Imposed social order based on the coded meanings attached to bodily appearance provided ways of regulating street activity.

Enforcing sumptuary laws became increasingly difficult as migration to cosmopolitan centres grew and establishing the identity of strangers became impossible. As a growing number of strangers crowded the streets, people continued to observe dress codes as known and proven methods of maintaining social order (Sennett 1977:65-67). Ensuing industrial developments and the promise of employment escalated the flow of disenfranchised farm workers into the cities. Mass-produced clothing became accessible to a wider range of people and determining class location based on dress codes became increasingly less reliable. It is worth mentioning here that contemporary laws such as those related to vagrancy continue to give law enforcers opportunities to determine what type of bodies are permitted to occupy public spaces leaving those with distinctive physical features (such as Aboriginals in Australia) particularly vulnerable.

Expansive urban landscapes of the late eighteenth and early nineteenth century developed largely around consumption. Simmel (1971:324) argued that the most significant problem confronting the individual was maintaining independence and individuality by resisting 'being leveled, swallowed up in the social mechanism' of the metropolis. Unable to process the ever-increasing extremes, diversity and stimuli of modern life the individual developed a 'blasé outlook' (Simmel 1971:329), where the only recourse to being noticed was 'to cultivate a sham individualism through the pursuit of signs of status, fashion, or marks of individual eccentricity' (Harvey quoted in Bocock 1992:126). Cades' quote highlights the amplified importance placed on the physical appearance and commodification of women within the context of the modern urban setting:

Everybody is thinking more these days about good looks. The bar has been raised for the jump. The passing mark is higher. Being good looking is no longer optional ... There is no place in the world for women who are not ... Competition is so keen and...the world moves so fast that we simply can't afford not to sell ourselves on sight. What if we are kind? And quick-witted? And make wonderful biscuits? ... People who pass us in the street can't know that we're clever and charming unless we look it (Cades quoted in Haiken 1995:91 from *Any Girl Can be Good Looking*, 1927).

The escalation of emphasis placed on physical appearance arose in tandem with the increasingly visual nature of Western cultures. Between the two Great Wars advertising flourished and the movie industry boomed. In the 1920s Americans spent more of their recreational money on going to the cinema than anything else and developed an insatiable fascination for the stars it spawned (Haiken 1995:96). The late nineteenth and early twentieth century the rise in consumer culture saw unprecedented growth in the cosmetics industry, particularly in America, where new techniques and products were advertised and actively marketed through the equally new, visually orientated, marketing methods. Victorian values which had previously held that beauty emanated from internal character and health were undermined as women came to view physical appearance as an external quality that could be altered. This rise in the beauty culture was initially seen both as democratising in its principles and offering employment opportunities to women. Improvements in cosmetics and hairdressing were viewed as equalising opportunities for self-improvement and transformation, providing all women with the means to enhance their appearance (Haiken 1995:19, 23).

Haiken (1995:99) observes that 'The American project of self-improvement provided the fabric into which ... new beliefs about beauty were woven.' In the increasingly secularised climate of the nineteenth century ideals of self-improvement promoted morality and character improvement. This focus, however, soon subsided, giving way to a broader, more expansive emphasis on personality which encompassed a wider range of characteristics including the presentation of self required to enable the individual to stand out in the increasingly competitive, crowded America of the twentieth century. Haiken (1995:100) carefully observes that ideals of self-improvement were not a direct call to embrace cosmetics or cosmetic surgery; rather, ideas about self-improvement were conceptually flexible and people were pragmatic in the ways they 'altered its particulars to reflect new circumstances':

With the progression from the spiritual quality of the soul to the moral quality of character to the all encompassing quality of personality, traditional boundaries between mind and body began to

blur: mental (or moral) qualities no longer seemed distinct from physical ones (Haiken 1995:100).

Ideals of self-improvement were in part mediated by the impacts of advertising. Ewan (1976) and Lasch (1978) argue that the role of advertising in America in the 1920s was a calculated move on the part of industrialists to educate the population to become consumers. Increased efficiencies in industrial processes resulted in mass production but the modernisation of capitalism required the vertical expansion of markets beyond the elite echelons of the upper and middle-classes, groups which production had previously focused upon, to include workers themselves. Shorter working hours and increased leisure time, the introduction of instalment payment systems and some increases in wages created conditions conducive for workers to embrace consumption. These notions, however, contradicted the virtues of thrift, sobriety and the work ethic promulgated in the previous century. Initiating change required habituating within the worker a 'physic desire to consume' (Ewan 1976:25). Advertising literature of the day spoke of engaging consumer instincts, the value of 'social prestige,' 'beauty,' 'self-adornment,' 'acquisition' and 'fancied need,' but the most effective methods borrowed from theories developed by psychologists of the day which appealed to 'feelings of social insecurity;' by directing 'the consumer's critical function away from the product and toward himself' advertising could amplify 'the "instinctual" anxieties of social intercourse' (Ewan 1976:35-38). The authors of the ethnographic study *Middletown* written in 1929 noted that the differing focus of advertisements from the previous generation concentrated

increasingly upon a type of copy aiming to make the reader emotionally uneasy, to bludgeon him with the fact that decent people don't live the way he does ... This copy points an accusing finger at the stenographer as she reads her motion picture magazine and makes her acutely conscious of her unpolished finger nails ... and sends the housewife peering anxiously into the mirror to see if her wrinkles look like those that made Mrs. X in the advertisement "old at thirty-five" because she did not have a Leisure Hour electric washer (Lynd, R and H. Lynd quoted in Ewan 1976:38).

Visual advertising and photography in particular invited consumers to interrogate and compare themselves with those photographed, an advertising technique recognised to heighten uncertainty. Advertisements fragmented the body into parts and offered solutions in the form of products to remedy each problematic area and inevitably guaranteed social success while cautioning that no one, not even the most beautiful, were beyond the risks of extreme scrutiny.

By 1929 more than 80% of all household spending was undertaken by women (Ewan 1976:167). It was largely women who assumed the responsibility of running the household while simultaneously inculcating brand preference and values of consumption in their offspring under the pervasive guidance of the corporate sector. Advertisements persistently emphasised a woman's appearance highlighting her commodified role in the socio-sexual politics of everyday life. Attention to her appearance was marketed as a way of ensuring her very survival in maintaining her husband's fidelity, impressing his superiors and securing her position within a marriage and access to his wage: 'While the skills of her mother and grandmother had been productive, her own were increasingly depicted as tricks of the flesh' (Ewan 1976:177,178). The half billion dollars spent on beauty products in 1927 alarmed many as it suggested a narcissistic preoccupation on the part of American women, but to others it was a source of national pride and in keeping with national beliefs of self-improvement. Advertisers also 'preached the parable of first impressions,' that life's fortunes could be destroyed or created by the immediacy of assessments impacted in first encounters, and, although cosmetic surgery was not yet common practice, cosmetic surgeons came increasingly to view their work within the context of these popularised beliefs (Haiken 1995:99-102).

Justifying cosmetic surgery

Developments in cosmetic surgery have paralleled developments in reconstructive surgery. However, the relationship between the two areas has historically been one of division and reconstructive surgeons initially distanced themselves from those performing cosmetic surgery. They argued that cosmetic surgery contradicted the basic tenets of medicine by catering to vanities, or worse still, enabled those who were morally suspect to pass as normal

and healthy. Reconstructive surgery was done for noble reasons, primarily to restore function which had been comprised by pathologies or trauma, whereas the pursuit of beauty was not seen as a justifiable aspiration of medicine (Gilman 1999). However, the distinction between cosmetic surgery and reconstructive surgery became increasingly blurred in cases such as harelip and facial reconstruction following trauma, where the aim of surgery was essentially for an aesthetically pleasing result. In the eighteenth and nineteenth centuries those performing cosmetic surgery had been derided as “quacks” and thought to place those they operated upon at risk. By the mid twentieth century efforts to integrate cosmetic surgery under the auspice of professional medicine were both an attempt to protect the public from the perceived risks presented by so-called quacks and an acknowledgment on the part of reconstructive surgeons that to concentrate on reconstructive work alone was to forfeit the far more lucrative and expanding market of cosmetic surgery (Haiken 1995). As Gilman wryly observes, conceptualising the shift from reconstructive to corrective surgery amid increasing demand requires ‘understanding the unalterable link between the psyche and the body ... in light of what the physician and patient imagine can and should be done to the body’ (Gilman 1999: xix).

The Great Wars provided an unprecedented opportunity for cosmetic surgeons to ameliorate the marginal status which they held within the medical fraternity, and to hone their skills rebuilding the shattered faces and bodies of returning soldiers. Here the line between reconstructive and aesthetic surgery again blurred as the aim was reconstructive but with an aesthetic outcome. Moreover, because the soldiers were most frequently men, cosmetic surgery became masculinised and cosmetic surgeons acquired status because the connotations of femininity and vanity previously attributed to cosmetic surgery were subsequently de-emphasised (Gilman 1999:166). Doctors argued, and few lay people disputed, the right of returning soldiers to be able to earn a living. However, ‘By expanding the definition of their work to include appearance, surgeons relied upon and reinforced the increasing cultural conviction about the social and economic importance of appearance’ (Haiken 1995:103). From this point it became increasingly difficult to discriminate against others for whom alterations in appearance might also enhance employment opportunities, thus adding to the growing number of justifications which cosmetic surgeons used to

legitimise their practice. Extreme financial hardship and the collective anxieties around employment experienced by Americans during the Great Depression served to reinforce these ideals and saw cosmetic surgeons embrace an 'increasingly Darwinian worldview, as they stressed that appearance had taken on importance in this ever more competitive world' (Haiken 1995:105).

Haiken (1995) observes that it was the growth of another science, psychology, which further added impetus to the cosmetic surgeons' claim to be recognised as a legitimate medical specialty and circumvented some of the more troubling ethical issues which had plagued practitioners prior to World War I. In 1910 the psychoanalyst Albert Adler theorised that the hierarchical relationships naturally evolving in families, when negatively experienced, can result in feelings of inferiority. Collating ideas from a variety of sources including Jung and Freud, Adler's theory became known as the 'inferiority complex,' and was widely written about in medical journals and the popular press alike. As Haiken (1995:112) claims, Adler may have conceptualised the inferiority complex but it was the 'American public that named it, endowed it with special meaning, and made it an icon of popular knowledge and culture.' The inferiority complex offered cosmetic surgeons a new paradigm from which to view their practice, one proposing surgical solutions to psychological problems. In 1936 Adler (quoted in Haiken 1995:116) wrote the introduction to prominent cosmetic surgeon Maxwell Maltz's book, *New Faces, New Futures: Rebuilding the Character with Plastic Surgery*, in which he proclaimed 'As we live in a group and are judged by the group, and as this group objects to any departure from normal, ... facial deformity can have a very deleterious effect on behavior.' Maltz (quoted in Haiken 1995:116) followed by describing how surgery might offer the means to conform to what might be deemed normal: 'Once normality is attained, the mind throws off its burden of inferiority, of fear of ridicule and economic insecurity ... The personality relaxes into naturalness and character is transformed.'

Cosmetic surgeons increasingly medicalised physical appearance by reclassifying the extremes of what had once been considered normal into deviations pathologised as defects or deformity. Such imperfections came to include any physical feature which caused feelings of inferiority and diminished life chances. The inferiority complex provided compelling

justification for cosmetic surgeons and significantly impacted how doctors and their patients reached agreement prior to proceeding with surgery. By emphasising the social, economic and psychological aspects of appearance surgeons began to share the diagnostic role with their patients, embracing their subjective evaluations in determining the actuality of deformity and the corrective surgical solution. In doing so surgeons relinquished the more objective professional role traditionally assumed by medical practitioners (Haiken 1995:123).

Medicine has traditionally been reductive in the way it defines the body. Using mechanistic and scientific reasoning the body is ordered and disciplined by segmentation into interconnected parts. By subjecting physical appearance to similar scrutiny and deciding what was acceptable and what was not, cosmetic surgeons positioned themselves within a medical framework and consequently defined their response as therapeutic. Nonconformist appearances became linked to deviance and illness (mostly psychological) and the subsequent expectations of the 'sick role' proposed by Parsons (1951) absolved individuals from responsibility for their condition and impelled them to seek medical assistance. In their study of cosmetic surgeons and patients who had undergone surgery, American sociologists Dull and West (1991) found that patients also fragmented their bodies into bit parts. Through shared perceptions which defined physical nonconformity as parts 'needing' to be 'fixed' patients and doctors mutually reached agreements about patient evaluations and potential surgical solutions. Such terminology also allowed surgeons to 'constitute *cosmetic* surgery as a *reconstructive* project ... Thus reductionism provides a means of resolving a central dilemma of cosmetic surgery – defining the nature and treatment of disease' (Dull and West 1991:63, original emphasis)

Looks do count

The rise in the cosmetic surgery industry has occurred within an environment in which changed values, cultural transformations, historical events and medical developments have all contributed to its expansion. The twentieth century has seen changes in occupational structure as declining employment in rural and industrial settings has given way to an expanding service sector and the subsequent growth of professional and managerial classes. The work environment of white-collar workers involves interpersonal interaction where the

emphasis on physical appearance has assumed an ever-increasing importance (Sullivan 2000:29). Changed working conditions have also exposed employees to subtle forms of discrimination which impact socio-economic outcomes.

The face is the location of our primary interactive organs; the mouth, ears and eyes are the primary sites of social interaction. Facial expressions, of which there are some 7000 (Ekman and Friesen 1978), communicate moods and emotions while topographical facial features such as skin colour and integrity signify identity, gender, age, race and health status. Furthermore, the face is the principle site upon which an individual is judged to be beautiful or ugly. Research has confirmed what most people have always known: the impact of physical appearance is pervasive and directly affects life chances. Berscheid and Walster (quoted in Synnott 1993:74) found that 'Students thought good looking persons were generally more sensitive, kind, interesting, strong, poised, modest, sociable, outgoing and exciting than less attractive persons.' Attractive children were socially and academically more successful and their teachers held higher expectations for them and more positively evaluated their personalities than their less attractive classmates. Attractive people elicited attention more readily when requiring assistance from strangers, were sentenced more leniently in simulated court cases, had higher paying jobs and were evaluated more positively in the workplace. In reviewing the research Patzer (in Synnott 1993:75) concludes that 'physical attractiveness touches practically every corner of human existence and does so with great impact. The research thoroughly documents the advantages of higher physical attractiveness and the disadvantages of lower physical attractiveness.'

In another study presented by Synnott (1993:77, 78), Kaczorowski conducted a panel survey of 4,000 full-time workers in Canada in 1977, 1979 and 1981 assessing the socio-economic significance of physical appearance. Interviewers were asked to assess the physical attractiveness of participants, assigning them to the categories of 'homely, average, good looking and striking,' and were also asked to assess the sincerity of participants. 37% of the sample were described as attractive or striking and were collapsed into one group considered attractive. The results demonstrated a clear link between aesthetic appearance and socio-economic advantage. Those considered attractive earned higher incomes, an average of 75%

more than those nominated as homely; the latter group earned only 57% of the income earned by those who were considered attractive. Moreover, those deemed attractive were twice as likely to hold a prestigious occupation and half as likely to have a low status occupation. Across both variables those who were of average physical appearance were evenly distributed through the range. Synnott (1993:77) notes that these income discrepancies are not dissimilar to male-female incomes in the UK and black-white incomes in the USA, suggesting that 'The semiotics of appearance seem to be as economically significant as the semiotics of gender and colour.' Furthermore, 81% of those nominated as attractive were believed to be sincere compared to 59% of the homely group. 19% of attractive people were considered insincere, while more than twice as many (41%) of the homely group were believed to be insincere. Synnott (1993:77) acknowledges the obvious questions this research raises: are the wealthy attractive because they are wealthy or because they are attractive? However, as this study was longitudinal, Kaczorowski applied regression analysis to show the degree of attractiveness was causal in impact upon the differentials of status and wealth. Synnott goes on to suggest this research demonstrates the presence of an 'aesthetic stratification system' which privileges those considered physically attractive, ensuring them improved opportunities for professional and economic success.

It is not only the physically unattractive who find they are socially disadvantaged, but also those who are ageing, in particular older women. Kathy Davis (2000) recalls the professional life of pioneering cosmetic surgeon Suzanne Noel (1878-1954). Noel was a resolute feminist who justified cosmetic surgery as an available technology which enabled women to remain viable within the workforce. She worked in France in the early part of the twentieth century as the medical specialty of cosmetic surgery was beginning to take its contemporary form. Noel, like many of her colleagues, extended her skills treating the facial injuries of returning soldiers from World War I, but her interest lay in surgically rejuvenating the ageing face. She developed the innovative 'mini-lift' for which she is most well known. Noel's unusual skill earned her widespread recognition at a time when few women were able to penetrate the highly masculinised domain of surgery. In 1926 she published a medical handbook in which she outlined her explanation for doing cosmetic surgery, followed by the surgical techniques she had developed. As an advocate for the right of women to work, Noel defended the 'bitter

need' for cosmetic surgery as embedded in social and material injustices, which denied professional opportunities to the older women who sought her services because their faces had aged. Davis (2000:7) writes that Noel used a feminist discourse and the rhetoric of choice, likening women's right to suffrage and a political voice to the right to be able to alter their face or body if they should choose to do so.

Positioning the ageing woman as an agent, Haiken (1995) makes a similar point when discussing the increasing numbers of middle-class women in post World War II America who sought facial cosmetic surgery. At a time when life expectancy had increased and older people were enjoying unprecedented affluence, national attention was captivated by their offspring, the generation of emergent baby boomers who bestowed primary importance upon youth and 'vowed not to trust anyone over thirty' (Haiken 1995:135). Haiken (1995:135) describes a developing ethos which 'encouraged Americans to find personal solutions to social problems' and saw ageing, increasingly invisible, middle aged women, as 'pioneers in this process of individualizing social problems of inequality.' For women who felt marginalised because of their appearances, engaging cosmetic surgery became increasingly accepted as an easier option than challenging the cultural and socially constructed norms of society at large.

In 1995 Davis published *Reshaping the Female Body: the Dilemma of Cosmetic Surgery*, which was the culmination of an extensive qualitative research project exploring the reasons women gave for undergoing cosmetic surgery. She recalls her discomfort with both the increasing numbers of women seeking cosmetic surgery and the commonly held feminist viewpoint which argues that women who undertake cosmetic surgery are 'nothing more than misguided and deluded' (Davis 1997:168). Gilman (1999) goes further to suggest that feminists use a simplistic victim/perpetrator model that pathologises women who have cosmetic surgery. Davis found that the stories women told made cosmetic surgery understandable in view of the particular circumstances of embodiment which participants experienced. She positions the women she researched as knowledgeable agents who chose cosmetic surgery as an act of empowerment to ameliorate the suffering and despair of living in a body that was not perceived as 'ordinary.' Women spoke not of having surgery to be

beautiful but to be 'just like everyone else' (Davis1997:169), confirming what Gilman (1999) later articulated as 'passing.'

In her study Gimlin (2000:77) too concurs with Davis (1995), agreeing that women who have cosmetic surgery are attempting to 'reposition their bodies as "normal" bodies.' She argues that cosmetic surgery succeeds for the women who undertake it but contends 'it works only within the context of a culture of appearance that is highly restrictive and which is less a culture of beauty than it is a system of control based on the physical representations of gender, age and ethnicity' (Gimlin 2000:89), echoing the sentiments of Douglas (1973) and Frank (1991) discussed earlier. Gimlin's (2000:95) interest lies in the question of identity in the aftermath of cosmetic surgery and how successfully patients realign their surgically enhanced bodies with the notion of an 'authentic' self. She points to the irony that although those who use cosmetic surgery have the right to cosmetic transformation as a route to approximating normality, the act of having cosmetic surgery itself invites claims that the character is morally tainted and the body inauthentic. Gimlin argues that the post-surgery attempt to deny inauthenticity is indicative of the way in which the women's self concept continues to remain 'deviant' despite the surgery which they seek to normalise their appearance. Questions of what constitutes an authentic body are invariably contentious. Gilman (1999) suggests that the underlying anxieties surrounding aesthetic alteration relate to the endless possibilities of transforming the human body, where the body is no longer a body but a simulacrum of a body from which the ability to determine authenticity is no longer determinable. With more people embracing cosmetic surgery or cosmetic procedures the concept of an authentic body may become something of an anachronism in the not-to-distant future and, perhaps if one were to consider the range of medical prosthetics now in use - intraocular lenses, cochlear ear implants, pacemakers and artificial joints, to name but a few - it already is.

Spreading the word: media and the marketing of cosmetic surgery

Women's magazines have traditionally informed women about domestic issues such as child rearing, clothes making and new household appliances. With the shift of women from the domesticity of the home into the work setting, women's magazines have redirected their

emphasis from home care to body care. Women's magazines have provided a boon for the cosmetic surgery industry in disseminating its latest procedures and techniques. A perennial fascination with the ever-changing bodies of celebrities adorns their pages, raising endless questions about the techniques employed to achieve 'the look.' Moreover, the language used to describe cosmetic surgery has retained the familiar, unthreatening vernacular of domestic production which in effect de-emphasises the risks such surgeries frequently entail. Abdomens are nipped and tucked, eyelids tidied and the skin lifted and re-draped over the face. Contemporary women's magazines aggressively target younger women and teenagers and the space previously dedicated to home-making has been taken over by copy dedicated to appearance: diet, exercise and advertisements promoting beauty products (Sullivan 2000:157). These themes are revisited in the following chapter.

Sociologist Deborah Sullivan (2000:155-180) carried out a content analysis of 17 leading American women's magazines between 1980 and 1995, examining 171 articles on cosmetic surgery published over that period. It is worth noting that this period included the Food and Drug Administration's inquiry into the use of silicon breast implants and articles relating to that inquiry accounted for 10% of all articles. Sullivan found the overall tone of the articles to be supportive of cosmetic surgery, the largest category of articles being informative. They described new techniques, discussed suitable candidacy for procedures, advised how to choose a doctor and often included lists of practitioners. The next most frequently presented category of articles provided autobiographical accounts of those who had had surgery. So-called 'rejuvenative procedures' such as face and brow-lifts were the most frequently discussed type of cosmetic procedure. The articles on facelifts that began appearing in the 1990s advised women to begin surgery in their thirties to diminish the inevitable impacts of ageing. The recent research of Victoria Blum (2003) suggests that embarking on the first cosmetic surgery initiates patients into a mode of surgically managing appearance which is potentially addictive.

Sullivan's (2000) research identifies women's magazines as powerful sites where dominant cultural norms about appearance are disseminated and reinforced. Articles link improvements in appearance achieved by cosmetic surgery to improved self-esteem and

mental well-being. Deviations from what were once deemed normal features of physical appearance - the vagaries of birth, changes incurred during pregnancy and breast-feeding, and ageing in particular - were represented in medicalised terms as flaws and deformities for which cosmetic surgery was recommended as a commonplace means of amendment. Once limited to performers and celebrities, cosmetic surgery was presented as a popular choice to a wide demographic, including teenagers, and promoted as affordable to all in 51% of the articles Sullivan examined.

However, in a study of the changing rhetoric surrounding cosmetic surgery found in popular magazines between 1968 and 1998, Woodstock (2001) found that although increasingly accepted, cosmetic surgery is still viewed as deceptive and vain. She suggests that, in the event of a public figure's credibility being questioned, having had cosmetic surgery is often presented as evidence of deviance or mental instability. Woodstock also observed a latent negativity emerging in the more recent magazine articles she examined where cosmetic surgery was not the main feature of the article but mentioned briefly within an article. Here cosmetic surgery 'almost always carries a negative connotation associated with vanity, frivolity, deception and violence,' which she interprets as 'an uncomfortability' with cosmetic surgery (Woodstock 2001:473). These observations, like Gimlin's (2000), suggest that there are underlying stigma processes surrounding cosmetic surgery which have not been conclusively presented in the empirical research I have encountered.

This chapter has introduced insights contained within academic writing on cosmetic surgery, exploring in particular the social contexts framing the history of cosmetic surgery and the cultural circumstances within which the technological advancements in cosmetic surgical practice have evolved. The demand for cosmetic surgery as a consumable grooming option has been seen as largely driven by an individual desire to conform to increasingly oppressive aesthetic standards which negatively sanction those who are deemed unacceptable or unattractive by the culturally formulated standards of the day. If we extend this argument it becomes clear that throughout its history, cosmetic surgery has responded to, and been engaged by, those who felt socially or financially disadvantaged by their appearance. The experiences of respondents in this study concur with this general position. However,

individuals who already feel disenfranchised also feel shamed by being denied entry to the social group to which they wish to belong, and it is an understanding of the anatomy of social exclusion that provides insight into the decision-making process around cosmetic surgery. The literature reviewed in this chapter helps to provide some understanding of this process, if only by signaling what has actually driven the growth in the cosmetic surgery industry. Women are the group most significantly impacted by cosmetic surgery and the next chapter considers feminist perspectives on the beauty system and reviews a range of selected views on cosmetic surgery.

Chapter Two: Women, Appearance and Cosmetic Surgery

The progressive normalisation of cosmetic surgery has alarmed feminist writers and social scientists alike. Consumer culture of late modernity has appropriated the body with a gaze steadfastly focused upon its appearance, preservation and health. Grooming industries, including cosmetic surgery, are major financial players in the global economy and, while men may be increasingly turning to surgeons to alter and rejuvenate their appearance, women remain the most avid seekers of surgical alteration. The female body, due in part to women's increased capacity for discretionary spending, has become a profitable site from which global economies mine billions of dollars, creating in their wake industries dedicated to promoting the maintenance, grooming and enhancement of the body, the ideals of which are relentlessly reiterated and reaffirmed in visual imagery and mediated forms. Appealing to self-preservationist ideals and emphasising particular bodily forms, society appears to reward women who approximate culturally constructed fantasies of the ideal body, while grooming industries extolling cosmetics, diets, exercise programs, the latest 'to die for' fashion, and, more recently, cosmetic surgery, have proliferated *en masse* to drive home a relentless message that there are consumable strategies for those who do not. Engaging women to survey and critically monitor their own appearance in ways that persuade them to believe they need to consume grooming products and services is the apparent lifeblood of grooming industries. Moreover, it is the way in which critical self-evaluation unfolds in the lives of women that is of interest to this study. This chapter examines the appearance dissatisfaction of women, and how it has been discussed in the literature and in relation to cosmetic surgery.

Adornment, dress, fashion and ideals relating to beauty are evident in all cultures. During the course of our lives we all participate in altering our appearance in some way or another. Both a necessity and pastime, adornment can be viewed as creative expression and is often associated with considerable pleasure. As Seid (1994:9) observes, 'How we choose to dress is a complex cultural phenomena. Clothing and adornment are simultaneously a material object, a social signal, a ritual and a form of art.' On an individual level, self-presentation is a performative process in which we construct an interpretive frame of reference to convey our beliefs, attitudes and identity to others (Goffman 1969). All cultures establish rules

around the presentation of self and, by adhering to expected codes of dress, normative behaviour and social values are expressed, perpetuated and reinforced. Citing the voluptuous nude, visually evidenced in hundreds of years of art work, Seid (1994:5) reminds us that western ideals about female appearance had, until the 1960s, been relatively consistent. Just one hundred years ago the most highly desired feminine ideal was antithetical to the slender, muscled contemporary ideal. She had a 'silken layer' or 'stored up force' of fat which indicated good habits, self-discipline, a pleasing temperament and, significantly, robust health. Then the dimpled flesh, today known and loathed as cellulite, was considered beautiful. For unfortunate thin women there was no recourse but to resort to inflatable rubber undergarments -complete with dimples- which were unreliable and prone to deflation at inopportune moments.

Feminists, in particular, have sought to uncover the ways in which women's bodies are implicated in their oppression. Second-wave feminists were concerned with sexual and reproductive autonomy alongside broader gendered inequalities, but the more recent corporeal questions to occupy feminists have related to identity, gender and the body. The sexual liberation of the female body inaugurated a number of changes, not least the way women's bodies came to be viewed in public life. Advertisers lost no time in selectively appropriating her newly liberated body to become an accessory to capitalism's successes. Eroticised 'ideals' were swiftly juxtaposed to objects of desire in advertising and the subsequent impact on the body images of ordinary women and their daughters concerned both lay audiences and feminists alike. At the forefront of feminist scholarship has been the vexing difficulty of explaining why women undertake harmful practices to manipulate their appearances while seemingly becoming co-conspirators in the authorship of those ideals which perpetuate their oppression (see for example Orbach 1978, Spitzack 1988, Bartky 1990, Wolf 1991, Bordo 1993, Smith 1993, Seid 1994, Davis 1995, Morgan 1995, Gillespe 1996, Fraser 2001, Covino 2004, Levy 2005, Martin 2007).

By way of introducing and framing the issue of bodily dissatisfaction which was overwhelmingly observed in the current study, this chapter considers contributions made by Naomi Wolf (1991), historian Roberta Seid (1994) and philosopher Elizabeth Grosz (1987)

prior to examining the specific issues surrounding cosmetic surgery by reviewing two seminal pieces written by feminist writers, Kathy Davis (1995) and Kathryn Pauly Morgan (1995), both of whom question women's motivations to undergo cosmetic surgery but arrive at very different conclusions. Davis and Morgan were engaged because a comparison of their work underlines the ethical problem one confronts when one assumes to represent the other as in the event of undertaking qualitative research. Morgan claims to speak for women who undergo cosmetic surgery but her footnotes reveal she drew upon secondary sources, whereas Davis used a qualitative approach and spoke directly to women who had undertaken cosmetic surgery. Morgan is deeply critical of women who undertake cosmetic surgery whereas Davis struggled to reconcile an absence of feminist theory to explain the articulated despair living in a despised body which her participants so emphatically disclosed. Bodily dissatisfaction through to bodily loathing quickly emerged as a dominant theme nominated by participants in this study and I similarly found myself struggling to find theory that could explain the undertaking of cosmetic surgery which did not denigrate or dismiss those who choose to enact it. Consequently, the ethical parameters drawn by Davis and Morgan relating to the contentious question of how one speaks for another, informed, guided, and, in very real ways, provided the starting point for this study.

The problem of beauty

In *The Beauty Myth*, Naomi Wolf (1991) contends that the increasing participation of women in the public sphere and the exponential growth in appearance related industries, which I collectively describe as grooming industries, are intrinsically linked. For Wolf the increasing power which women fought hard to attain has been paralleled by increasingly constraining images of women projected in advertising and media. Reflecting on the decade that was the 80s, Wolf (1991:10) highlights the following points: there was a disturbing proliferation of eating disorders, cosmetic surgery became the fastest growing medical specialty, pornography became the largest media category eclipsing recorded music and mainstream films combined, and, in 1984 'thirty three thousand American women told researchers that they would rather lose ten to fifteen pounds than achieve any other goal.' At an unprecedented moment in history, as women made inroads into public life and breached the most powerful institutions, their collective momentum stalled. Pervading the lives of

attractive, successful women, Wolf (1991:10) writes: 'there is a secret "underlife" poisoning our freedom; infused with notions of beauty, it is a dark vein of self-hatred, physical obsessions, terror of aging, and dread of lost control.' This, she contends, is no accident. Rather, it represents a calculated enactment of social control directed towards second-wave feminism to curtail the trajectory of equality being realised by its visionaries, a covert attempt to psychologically preoccupy women with their perceived physical inadequacies and undermine their newly acquired freedoms.

Underpinning Wolf's beauty myth is a number of contested, but nonetheless widely held notions. The first upholds a clearly defined ideal of beauty, emanating from a singular Platonic model, as conceptually universal. The second proposes that evolutionary success is biologically determined and requires the strongest men compete for the most beautiful women. Together these reinforce an overarching belief that it is imperative to women's reproductive and social success to embody the prevailing cultural ideal of beauty, but as Wolf (1991:13,14) argues, the historical and biological legitimacy of the beauty myth has less to do with aesthetics and more to do with the maintenance of patriarchal power. While the focus of the myth is on appearance, appearance is merely a transient construction symbolic of desired female behaviour in any given period. What is more significant is the prescriptive behaviour the myth elicits which damages and divides women. By valorising youth and beauty, Wolf contends, the strength, skills and knowledge of ageing women are discredited. Women compete against each other, ageing is abhorred and feared, and the intergenerational bonds between women fray through mutual mistrust. As the feminine identity of women became closely linked to youth and beauty, women became increasingly susceptible to the approval of others, and their self-esteem progressively more fragile. Consequently, the way in which the beauty myth impacts upon women is to undermine them psychologically by arousing unconscious anxieties which make them feel ugly. Research by Cash *et al.* (in Wolf 1991:239) found that there is little connection between the attractiveness of women and their own perceived attractiveness, as the women under study did not compare themselves to other women but to fashion models. Regardless of their appearance even those considered the most beautiful will never feel beautiful enough. The beauty myth is, as Wolf

defines it, not about cosmetics, fashion or surgery but about how women are encouraged to feel about their bodies.

Wolf (1991) traces contemporary ideas of beauty back to the 1830s when the social changes inaugurated by industrialisation and urbanisation saw the productive familial unit fragment into 'separate spheres.' Men increasingly left the home to participate in employment in the public domain, while women withdrew to the domestic setting and a role supportive of the breadwinner. With industrialisation came the proliferation of mass produced visual imagery in the form of photographs, postcards and figurines. By mid-century advertising flooded the domestic sphere with images telling women how they should look. Wolf (1991:15) writes: 'Since the Industrial Revolution, middle-class women have been controlled by ideals and stereotypes as much as by material constraints.' There is more than a whiff of conspiracy permeating Wolf's argument, which at its heart suggests women's oppression has occurred because a reified patriarchy has immobilised middle-class women by compelling them to become obsessed by the inadequacies of their physical appearances. Wolf (1991:15) herself counters this with a claim that her version of a beauty myth is a 'uniquely plausible' cultural conspiracy. Moreover, she contends, beliefs beauty belonged to the feminine domain is another 'social fiction.' Social fictions follow what Ibsen called 'vital lies,' deceptions that occur within families, an idea that was later expanded by Goleman (quoted in Wolf 1991:17) to encompass a wider social level where 'collusion is maintained by directing attention away from a fearsome fact, or by repackaging its meaning in an acceptable format' resulting in societal blindness to the destructive nature of communally constructed illusions. While there are problems with aspects of Wolf's argument she nonetheless touched on a nerve in making public the body loathing many ordinary women understood as reflecting their own private experience.

Wolf made 'the personal political' with her publication of *The Beauty Myth* by successfully engaging ordinary women and enunciating a bodily dissatisfaction they recognised, located within a socio-cultural context they knew. Moreover, the phenomenal success of *The Beauty Myth* underlined the potential for feminist scholarship to connect with a broad range of women by offering them new ways in which to think about issues relevant to their lives and

their bodies. However, in line with sensibilities of the day (and Morgan's 1995 discussion likewise), Wolf did overlook the agency employed by women in negotiating broader culture ideals. This obvious criticism aside, *The Beauty Myth* remains a pertinent exploration of the way in which women are impacted by broader cultural constructions of body image.

Indeed, Wolf gives much attention to women's magazines, claiming that they have been highly influential in disseminating and reinforcing the social fictions which redefine the feminine identity of women and uphold the beauty myth. With increasing literacy and purchasing power among middle and lower-class women, magazines and the accompanying advertising directed women to what was expected of them and what they should buy. Studies of women's magazines have shown that during both World Wars women were mobilised to both paid and volunteer work to maintain industrial production while their husbands and sons fought in the trenches. With newly acquired wealth, status and responsibility, between 61% and 85% of American women surveyed in 1944 stated emphatically that they did not want to return to their lives as wives and mothers at the end of the war (Wolf 1991:63). This presented a significant problem to the Manpower Commission in the USA which envisaged widespread destabilisation if returning veterans were displaced from employment by low paid female workers. As three million American women and one million British women had their positions terminated, women's magazines reaffirmed their domestic role.

The movie industry reinforced the theme. In the 1950s the last fleshy icons of the century, immortalised by Marilyn Monroe, graced movie screens and magazine covers. Bordo (1993:208) writes: 'It is not until the post-World War II period, with its relocation of middle-class women from factory to home and its coercive bourgeois dualism of happy homemaker-mother and responsible, provider father, that such clearly defined bodily demarcation of "male" and "female" spheres surfaces again.' Women may have developed new skills beyond the domestic sphere during the war, but at the end of the war their normative role was directed back towards the family and containment within the home. Wolf (1991:64) writes: 'Women's magazines for over a century have been one of the most powerful agents for changing women's roles, and throughout that time – today more than ever – they have consistently glamorized whatever the economy, their advertisers, and, during wartime, the

government, needed at that moment from women.’ At the same time Wolf (1991:70) defends the role women’s magazines play in women’s lives fulfilling a unique role in that they are largely compiled by women, take the concerns of women seriously, and represent to women a window to women’s mass culture. However, she makes an important distinction between the intentions of editors and the limitations imposed upon them by advertisers. In 1956 a nylon company first bought space in a women’s magazine on the proviso that no other articles featuring natural fibres would be featured, thus introducing what would progressively become a complicit relationship between the editors and their advertisers. Wolf (1991:81) cites several instances where companies such as those manufacturing cosmetics and hair dye flexed their financial muscle by withdrawing, or threatening to withdraw, their accounts when magazines ran articles promoting grey hair or not wearing make up. In 1997 Cyndi Tebbel, the then editor of the Australian magazine *New Woman*, ran a story promoting body diversity and placed a size 16 model on the cover. A cosmetic company advertising in the magazine withdrew its account and Tebbel was subsequently sacked. Articles in the magazine returned to those ‘promoting body insecurity and promised cures,’ but this event made it clear that the ‘material interests of the cosmetics, fitness and fashion industries will not tolerate a message that acts against their commercial interests – that is, a message challenging the dominant ideal of female beauty’ (Williams and Germov 1999:216). The reliance of magazine editors on the financial support of their advertisers compromises their copy and coerces their tacit acquiescence in the manipulation of feminine identity.

In the period following World War II advertisers recognised the significance of women as consumers and began to buy advertising space in magazines through which they aimed to sell household appliances and products. Where housewives lacked a distinct identity, marketers aimed to create one for them linked to the consumption of purchasable products. Freidan’s investigation of a marketing company (in Wolf 1991:64,65) uncovered calculated and manipulative techniques designed to undermine women psychologically by promoting insecurities and guilt about filth in their homes, while elevating the drudgery of endless housework to the status of a specialised knowledge related to specific products by imbuing their use with ‘religious beliefs’ or ‘spiritual rewards.’ Wolf updates Freidan’s argument to accommodate the decline in the housewife market as women increasingly ventured into the

labour market. Subsequently, she argues (1991:66), the focus of women's consumption shifted from their homes to their bodies. Moreover, persuading women to purchase products to enhance their appearance required instilling within them similar anxieties to those that had encouraged them to purchase for their homes. The role played by women's magazines would again be pivotal.

Once second-wave of feminists had deconstructed the social fiction of domestic fulfillment in suburban homemaking promulgated in women's magazines, the magazine version of femininity no longer appealed to women. As women left their homes and ventured into the workforce their appetite for women's magazines waned. Between 1965 and 1981, British sales of women's magazines dropped from 555.3 million to 407.4 million as the relevance they once held in women's lives evaporated (Wolf 1991:67). All that changed when, in 1969, *Vogue* magazine, itself confronted by flagging sales and diminishing interest in the high-end fashion which had once been the cornerstone of its enduring popularity, introduced the 'Nude Look,' in effect shifting the site of anxiety from the domestic setting and the dictates of fashion to the more intimate zone of the body itself. Wolf writes:

[A]ll that was left was the body... Stripped of their old expertise, purpose and advertising hook, the magazines invented - almost completely artificially - a new one. In a stunning move, an entire replacement culture was developed by naming a "problem" where it had scarcely existed before, centering it on women's natural state, and elevating it to the existential female dilemma (Wolf 1991:67, original emphasis)

Fashions were changing, layers were being removed, mini-skirts, midriff tops and the liberalisation of censorship had seen unprecedented public exposure of the female body (Seid 1994:10). Sensing social change and, as Wolf (1991:67) suggests, in a desperate attempt to revive flagging magazine sales, uncovering the body signified a change in focus from clothes and accessories to the actual body itself. Notions of fashion and beauty have always been intertwined. The dictates of fashion had once centered on what to place on the body but in removing clothing the focus became the body itself. By exposing the female body undressed women's magazines embarked upon a new agenda, informing women how their bodies should look and revealing to them anatomical flaws which, up until then, they had not been

aware they possessed. The most visible idealised, bodies of actresses, models and beauty contestants were mirrored by only 5-10% of the population. With devastating impact a statistically deviant group became normalised, leaving the majority of women to feel overweight (Seid 1994:8). Containing and controlling the margins of the body assumed unprecedented importance, legitimised in part by the medical profession's concern about rising obesity.

Seid (1994), however, believes that increased concerns about slenderness should not be blamed on fashion alone. Rather, she contends, they emerge from a history replete with contradictory beliefs about virtue, beauty, appetite, eating and health. Seid describes the emerging culture of slimming, which has steadily gained momentum in post-war America, as arising from concerns that people were becoming more sedentary, eating more and getting fatter; a fear people were becoming both 'physically and *morally* soft' in response to the opulence and increased leisure afforded by modernity. 'Fatphobia' emerged as a central theme which proscribed: 'animal fat of any kind - on the body, in the blood, on the plate - as dangerous' (Seid 1994:6, 7). Highly contested charts stipulating ideal weight for height ratios were implemented decreeing that anyone with enough willpower could achieve their ideal weight. By emphasising democratising principles of self-help, slenderness assumed the position of virtuous moral elevation, while being overweight became imbued with degradation and implied dirt, shame and lack of self-control. Those affected had only themselves to blame. Similar concerns arose in Australia as the weight of the population also increased and medical researchers, concerned about the productivity of the population, made links between rising health costs, premature death and obesity. Williams and Germov (1999:209) note, that during the 1970s, 'a rare coalescence of factors emerged to reinforce the thin ideal: medical science, government authorities, and the fashion industry all adopted an anti-fat stance,' in effect legitimising and reinforcing the idea the healthiest and most desired body was one devoid of fat. This provided an enormous boon to emerging body centered grooming industries.

Capitalising on the public undressing of women and increased scrutiny of their bodies, the rise in the medical specialty of cosmetic surgery has been little short of spectacular. Despite

predominantly affecting women, feminist interest in cosmetic surgery was initially slow but in the past decade, as the profile and demand for cosmetic surgery has accelerated, the academic interest in cosmetic surgery has gathered in momentum. Early commentary on cosmetic surgery focused on the medicalisation and technicalisation of women's bodies by the patriarchal institution of medicine (Spitzak 1988, Wolf 1991, Balsamo 1992, Morgan 1995), and the discursive analysis of the concept of 'choice' in the promotion of cosmetic surgery (Gillespie 1996, Brush 1998). Theoretically, these writers were generically feminist in that they viewed women who had undertaken cosmetic surgery as oppressed by culturally constructed imperatives which sought to reinforce and maintain the objectification of women while ensuring the institutional dominance of patriarchy. In addition, feminists have examined the impact of women's magazines in normalising and informing women about cosmetic surgery (see Wolf 1991, Sullivan 2000 and Woodstock 2001, Fraser 2003, Jones 2004). More recent feminist scholarship has explored the phenomena of cosmetic surgery as it has been presented in its latest and potentially most powerful medium: the televised makeover format (Covino 2004, Heyes 2007, Pitts-Taylor 2007, Jones 2008a, Jones 2008b). Qualitative studies which sought to understand women's engagement with cosmetic surgery have been done by Dull and West (1991), Davis (1995), Gimlin (2000, 2002, 2006, 2007), Huss-Ashmore (2000) and Blum (2003). Davis (1995, 1997, 1998, 2000, 2003) stands out as one of the most consistent commentators, having written numerous articles emphasising that women's engagement with cosmetic surgery is complex, particularly when the accounts of those who have undertaken it are considered. In her largest qualitative study Davis (1995) identified her participants as knowing agents employing cosmetic surgery as a means to alleviate the suffering of living in a body they despise. She found her participants engaged cosmetic surgery as a strategy to resolve the disembodiment wrought by body loathing and argued, contentiously, that they used cosmetic surgery to become 'embodied.' Davis' stance has been the subject of considerable criticism from other feminists and she has been derided as a supporter of cosmetic surgery (Davis 1995).

Wolf (1991) too gives cosmetic surgery considerable attention in *The Beauty Myth* under a chapter called 'Violence.' She views cosmetic surgery as an escalation of the abuses – disordered eating and excessive exercise - inflicted upon the bodies of women in order to

maintain the ideal of slenderness. She argues that the modern 'Surgical Age' has its precedent in the nineteenth century when healthy middle-class women were deemed to be sick and active women were coerced into passivity (Wolf 1991:220). Wolf revisits the Victorian cult of invalidism and the nineteenth century diagnosis of hysteria to illustrate how the normal healthy physiology of women was reinterpreted as pathological. In Victorian times it was believed that the participation of women in modern society and their subsequent quest for education and employment would result in disease. It was feared that exposure to the cosmopolitan lifestyle enjoyed by men – rich food, late nights and gaslights in the streets – would cause illness. Middle-class women withdrew, invalided, to the sanctuary of the home. Their pursuit of learning was also thought to damage their reproductive organs and thwart their sexuality. Engels proclaimed that 'protracted work frequently damages the pelvis,' 'education would sterilize them,' and taking an interest in masculine pursuits such as science would result in diminished sexual attractiveness. He wrote: 'When a woman displays scientific interest, then there is something out of order with her sexuality' (cited in Wolf 1991:225). Victorian doctors described all facets of reproduction as illness, similar to the way contemporary doctors describe the naturally occurring physiological changes of reproduction – the natural weight gain of pregnancy, stretch marks and the softening of breasts subsequent to lactation – as diseases and deformities amenable to surgical transformation:

The nineteenth-century version of medical coercion looks quaint to us: How could women have been made to believe that menstruation, masturbation, pregnancy, and menopause were diseases? But as women are being asked to believe that parts of our normal, healthy bodies are diseased, we have entered a new phase of medical coercion that is so horrific that no one wants to look at it at all (Wolf 1991:223).

Wolf (1991) locates cosmetic surgery in a continuum of beliefs about health and illness traditionally overseen by men or patriarchal institutions, of which modern medicine is a recent incarnation. English and Ehrenreich (in Wolf 1991:221) emphasise that: "Medicine's prime contribution to sexist ideology has been to describe women as sick, and to describe women as potentially sickening to men." The equation of femaleness to illness is thus a culturally constructed fiction that has been, and continues to be, immensely profitable to the

medical profession. Contemporary medicine has moved closer to fashion in proclaiming that the pursuit of beauty is synonymous with the pursuit of health. The third collaborator in this financial juggernaut is advertising. After all, complacent women who are content with their appearance are unlikely to be bothered consuming products and services which promise physical transformation.

Cosmetic surgery, aesthetics and the body as surface

The modernist biomedical metaphor for understanding the body was one that reduced and fragmented the body into mechanised parts in which normal bodily function depended on precision-like interaction to work. Illness was understood as malfunction and understanding the systemic relationships enabled intervention. Pushing this fantasy to its inevitable limits envisages reconfiguring the body, replacing organs, altering genetic codes and rearranging bodily features. Destiny need no longer be constrained by anatomy. Morgan (1995:310) writes that 'What is designated "the natural" functions primarily as a frontier rather than a barrier.' She goes on to quote a plastic surgeon: "Patients sometimes misunderstand the nature of cosmetic surgery. It's not a shortcut for diet or exercise. *It's a way to override the genetic code*" (Morgan 1995:310, original emphasis).

Balsamo (1992) suggests that modern technologies like medical imaging which scan the body, visualising its interior with endoscopy and the unravelling and decoding of genetic material are transforming the body into a visual medium. While these technologies further fragment the body internally into ever-reducing minutiae, they also flatten and disperse its surface into a textual image upon which the border or margin is increasingly viewed as fluid and available for redefinition. Employing computerised imaging, the consulting cosmetic surgeon can reproduce a client's face on a screen and manipulate facial features to illustrate how proposed modifications will, in theory, look when surgical modification is performed. Flesh is tightened or removed, visually reinforcing the power of medicine and the malleability of the body. Re-imagining their own images before the mirror, participants in this study described similar processes in their pre-surgical rehearsal of enhanced body image.

Cosmetic surgeons are frequently encouraged to familiarise themselves with art works of the body to create templates of the most desired facial features and body shapes. Reviewing *Proportions of the Aesthetic Face*, a text studied frequently consulted by cosmetic surgeons, Balsamo (1992:211) observes that the 'ideal face' is Caucasian and perfectly symmetrical, both in profile and frontal view. By adhering to standardised templates surgeons participate in the reproduction of idealised beauty and normalising processes where scalpels quite literally inscribe culture onto flesh and, no less literally, transform the body into a cultural product. Indeed, a quick flick through any women's magazine attests to the homogenising effects of narrowing beauty standards as it is becoming increasingly difficult to discern one celebrity's face from another. But perhaps even more worrying, cosmetic surgeons promulgate aesthetic values that veer perilously close to eugenics by promoting a physical ideal which is representative of white, standardised beauty.

Bordo (1993:246) contends that the very materiality of the body has been replaced by 'cultural plastic' where 'intoxication with freedom, change and self-determination' demonstrates a disdain for the material limits of the body, while denying its lived and social realities. Perceiving the body as a surface disregards the embodied experience of the material body and hides the pain, bruising and disappointment of undergoing surgery. Finkelstein (1991) evokes revulsion as she recounts graphic descriptions of cosmetic facial surgery and procedures. Chemabrasion, a procedure used to delay a surgical facelift, removes fine superficial wrinkling by inducing a chemical burn:

In chemabrasion, an exfoliative agent such as phenol or diethyl ether is applied to the face in a mask. The chemical penetrates below the superficial level of the skin, burning it; the face goes numb, the skin turns white, then red and begins to swell. Within a few hours the skin has turned brown. A second-degree burn to the face has been induced ... On the third day a crust of dead skin begins to form ... It can take ten to fourteen days before the crust of dead skin is fully removed from the face, leaving an inflamed raw look (Meredith in Finkelstein 1991:98)

She goes on to write that the redness can persist for months. Patients must avoid the sun and may have limited mouth mobility because of the skin tension that results, and so it goes on, procedure after procedure described in minute and gruesome detail (Finkelstein 1991).

French performance artist Orlan has appropriated cosmetic surgery as a way to recreate, redesign and reinvent her own flattened-out self-portrait. Using the facial features of five archetypal women, she created a blueprint for the re-formation of her face. Her surgical operations were media events, staged and televised to various global locations, with Orlan and surgeon in costume, she reading verse on occasions, with dancers present and music playing. Orlan did not use general anesthesia. She recorded photographic evidence of her healing, and exhibited, and later sold the blood-engorged swabs, superfluous tissue, fat cells and bone as pieces of art. One of her most commented upon interventions has been small implants inserted in her forehead to resemble bud-like horns. Interpreters of her work claim it that it “de-naturalizes” and de-stabilizes the fixity of identity’ and conventional ideas about beauty and the materiality of the body (Negrin 2002:33). Orlan herself has gone so far as to claim that the body is obsolete. However, as Negrin (2002:34) suggests, Orlan may not be so different from other women undergoing cosmetic surgery in that she seeks to transcend nature through technology and in doing so reinforces a key myth of patriarchy. (For a more detailed discussion of Orlan’s work see Brand 2000 or Jones 2008a).

Elisabeth Grosz (1987), like Bordo (1993), is concerned about the materiality of the body. She proposes that the body be re-conceptualised to incorporate or acknowledge the relationship between its inscriptive surface and experiential internality, a relationship that she describes as each part mutually conditioning the other. Grosz (1987:1, 3) rejects the notion of female essentialism and Foucault’s idea of a pre-cultural given, claiming that ‘the body can be seen as *the* primary object of social production and inscription, and can thus be located within a network of socio-historical relations ... As a socio-historical ‘object,’ the body can no longer be confined to biological determinants, to an *immanent*, ‘factitious,’ or unchanging social status.’ Rather than a fixed entity the body needs to be recognised as a ‘*political* object,’ malleable and plastic, able to be reclassified in alternative ways to the prevailing dichotomised models. Then, as a socially constructed object, the body can be culturally contested and reformulated (Grosz 1987:2, 3).

By deconstructing Cartesian dualism Grosz (1987) demonstrates the way in which inherently hierarchical relationships have privileged mind over body, subjectivity over objectivity, male

over female, sciences over social sciences, mind over culture and culture over nature.

Descartes ranked material objects into degrees of complexity locating the 'brute matter' of the body in a continuum of organic matter, including trees and rocks, which acknowledged the body's exteriority and disregarded its interiority. As Grosz observes, 'The animation and *interiority* of the body, the fact that it is the point of origin of a *perspective* and that it occupies a conceptual, social and cultural point of view, cannot be explained on such a model;' within the Cartesian model, the very 'humanness of the body, its *psychical* status, has been ignored' (1987:5, original emphasis).

Underpinning patriarchal oppression is an embedded belief that the role of women is tied to their corporeality, to nature, and their social function fixed to their reproductive capacity, which locates them closer to nature than men, and dependant upon them. Dependence within the framework of patriarchy reduces women's position to that of children and increases their vulnerability to the experience of shame, particularly in relation to their bodies. Extricating the female body from a male-defined, biological account is believed by many feminists to be a necessary move in creating positive representations of women and feminine identities.

Grosz (1987:7) proposes the body be thought of in alternative ways which are not biologically reductive. She argues that subjectivity does not simply emerge from biological processes but manifests from social, economic, psychical and moral relationships where the ideological values of any given social group are acquired, reproduced and recorded, or inscribed upon the body. Through these processes individuals become 'branded,' socially tattooed, which determines their role in a particular cultural order (Grosz 1987:12). Grosz is not, however, proposing a post-biological body, rather she is rejecting the notion of dualism. She contends (1986:7) that because human bodies create culture, 'Human biology must be *always already cultural*' for culture to be effective upon it. The body, Grosz (1986:7) continues is '*naturally social*;' it is therefore 'a threshold term between nature and culture, being both natural and cultural' (emphasis is original).

Our relationships to our bodies are rarely benign. As social beings our bodies are important to us, we assign meaning to our biology and the existence and experience of our corporeality. Drawing from Lacan and Freud, Grosz (1987:8) notes 'the body and its various organs and

orifices – are always psychically or libidinally mapped, psychically *represented*, as a condition of the subjects ability to use them and to include them in his or her self-image.’ The body is thus as a ‘*hinge*’ or ‘*threshold*’ between nature and culture. It is continually traversed by organic and psychical drives and is, as a consequence, ‘*both* biological and psychical.’ Alternatively the body can be seen as the juxtaposition of embodied subject and inscriptive surface, or ‘the *interface* between ‘privatized’ experience and signifying culture’ (Grosz 1987:10). While the exterior of the body is subjected to socialisation and acculturation processes and the acquisition of appropriate beliefs and values, the interiority of the body also emerges from the external, inscriptive processes. Locating women at such an interface and acknowledging the importance of the psychic, social and biological dimensions in understanding the experience of embodiment is extremely useful in unpacking the complex ways by which women negotiate culture, identity and body modifications like cosmetic surgery.

Despite both Grosz’ (1987) and Mauss’ (1973) proposals that fully comprehending the body and the way in which people manage it require a diverse approach, contemporary feminist commentators like Holliday and Sanchez-Taylor (2006) have questioned a number of key ideas espoused by early writers exploring the phenomenon of cosmetic surgery. To their credit, they do examine feminist critiques of beauty to argue that white middle-class feminists have, in failing to recognise the social value attached to beauty, denied its importance to lower-class women and women of race as a medium through which they might accrue social capital (Holliday and Sanchez-Taylor 2006:184). However, in a move that is oddly contradictory, they also take issue with previous conceptualisations of cosmetic surgery as enacted in response to suffering or psychic pain. While contemporary cosmetic surgery tends to be undertaken most frequently by women, the previous chapter argued that the history of cosmetic or aesthetic surgery has not been framed by gender, but by stigma. The motivations of those who pioneered its use have been characterised by the desire to efface physiological traits which were perceived to inhibit access to privileged social domains (Gilman 1999, Haiken 1995, Sullivan 2000). The subjective experience of stigma, and the social exclusion which accompanies it, invariably involves some degree of psychic pain. Holliday and Sanchez-Taylor, however, argue that an emphasis on psychic pain as a

motivation underpinning the desire to undertake aesthetic surgery does not account for surgical intervention as a consumptive choice. They propose the terms 'self-improvement' and 'enhancement,' which suggest working with the body one has rather than transforming it into something different, as alternative categories through which cosmetic surgery might be understood. The current study found an intense dissatisfaction with one's appearance, or an aspect of one's appearance was a significant feature in the initial decision to have cosmetic surgery, but the decision to have additional cosmetic surgery was often framed around managing social status through the perceived enhancement or improvement of appearance. Findings from this study suggest the rationale for undertaking cosmetic surgery does change with subsequent surgeries. While the first surgery demands extensive consideration, subsequent surgeries were often articulated as self-improvement measures. Although these terms have not been fully conceptualised in the current study, the way in which Holliday and Sanchez-Taylor suggest they might be used appears overly simplistic.

Beverly Skeggs (1997) observed the working-class women whom she studied sought to transcend class through self-improvement. Self-improvement was sought, particularly at the level of the body, to enhance social value precisely because the women she interviewed felt undervalued. Skeggs' interviewees understood the potential for moving from the lower-class could only occur through the medium of self-improvement. By continually making comparisons with others, they were able to differentiate themselves from those they perceived as failing to improve. Through improving and managing their appearance working-class women attempted to pass as middle-class, but because they were denied access to the cultural capital required to fully apprehend the inscribed middle-class body, they were always vulnerable to failure. As a consequence, their attempts to pass as middle-class were inevitably tempered with shame. Feeling susceptible to the judgments of others, in combination with a perpetual doubt about their own judgments, writes Skeggs (1997: 90), underlines 'the emotional politics of class.' If we are to believe Skeggs, then, the desire to self-improve is unlikely to be devoid of specific intentionality within which a psychic dimension has been invested.

Participants in the current study did, on occasion, claim to have cosmetic surgery as a consumptive choice. It was most frequently offered in response to the question, “Why did you decide to have cosmetic surgery?” The answer usually went, “I did not like how I looked. The technology was readily available and I could afford it, so, why not?” But such a response tended to be given at the very beginning of the interview and was, what I would describe, a short answer. The tenor of such a response is more defensive than it is explanatory and further discussion invariably produced a more complex rationale which suggested the relationship between the self and its body image is often complicated for those who seek surgical enhancement. Although this study advances the idea that shame and narcissism were implicated in the enactment of cosmetic surgery for those who took part in this study, in the current climate where attitudes towards cosmetic surgery are highly fluid, it is likely the accounts given by those who engage cosmetic surgery will, over time, change, and vary from one socio-cultural context to the next (see for example Gimlin’s 2007 study). These speculations aside, a central aim of qualitative research concerns moving beyond the short answers, with a view to exploring the more detailed accounts which the in-depth interview process encourages and, indeed, seeks to facilitate. Two seminal works in the feminist writing on cosmetic surgery claim to be qualitative, but their methods and findings are contentious.

Extreme views: two feminist studies on cosmetic surgery

Philosopher Kathryn Pauly Morgan (1995) has written one of the most important commentaries on cosmetic surgery reflecting a feminist standpoint. ‘Women and the Knife: Cosmetic Surgery and the Colonization of Women’s Bodies’ first appeared in the feminist journal *Hypatia* in 1991. Her tone is unambiguously one of outrage. She begins by asking her readers to imagine knives and needles cutting into their skin. Morgan declares bewilderment as to why women are choosing to have cosmetic surgery, yet her opinions about cosmetic surgery and the women who undergo it are clearly apparent. She calls for a feminist analysis ‘to understand why actual, live women are reduced and reduce themselves to “potential women” and choose to participate in anatomizing and fetishizing their bodies as they buy “contoured bodies,” “restored youth,” and “permanent beauty”’ (Morgan 1995:306). Morgan claims it is necessary, indeed ethical, to listen to the reasons which women

themselves give for having surgery. She offers eleven statements from different women explaining why they had surgery, presented in a way that appears to trivialise both the women and their motivations as passively fulfilling an ideal of patriarchy. Checking her footnotes for the origins of these 'voices' reveals they were sourced from newspapers (*The Toronto Star* and *New York Times*). So, these voices were not heard first hand but come filtered by reporting journalists and newspaper editors. In a move that is ethically questionable, Morgan (1995) does not disclose her recruiting methods, nor make clear how or why she chose particular 'voices,' thus obscuring the fact that she did not speak personally to any women who had undergone cosmetic surgery.

In deconstructing the notion of choice around the decision-making processes required to undergo cosmetic surgery Morgan (1995) makes a number of largely unsubstantiated claims. She argues that women who undergo cosmetic surgery have a desire to appear young and beautiful to please men and, in order to achieve that aim, conform to 'deeper ... norms of compulsory heterosexuality' while desiring 'not simply beautiful bodies but white, Western, Anglo-Saxon bodies in a racist, anti-Semitic context' (Morgan 1995:315). Cosmetic surgery reduces women to the materiality of their bodies, to a 'potential, a kind of raw material to be exploited in terms of appearance, eroticism, nurturance, and fertility as defined by the colonizing culture' and they are coerced into having cosmetic surgery by 'brothers, fathers, male lovers, male engineering students who taunt and harass' them 'and by male surgeons who offer "free advice"' (Morgan 1995:316). Morgan contends that the choice to undergo cosmetic surgery might appear to be liberating and empowering to women, but in reality it increases their need for acceptance from a masculinist 'other' 'which is male-supremacist, racist, ageist, heterosexist, anti-Semitic, ableist and class-biased' (1995:318). Furthermore, the concept of choice is masked when cosmetic surgery becomes progressively normalised as an accessible, obligatory technology of the body, and those who decline surgery became stigmatised as deviant because they choose not to have it, thus refusing to take the option of self-improvement. Those who resist cosmetic surgery risk not only being labeled 'ugly' and 'old,' but relegation to the underclass of a select population of the eternally youthful, surgically enhanced (Morgan 1995:321). Morgan's argument is passionate, but let down because she is locked into a simplistic, dualistic victim/perpetrator model where power is

always masculine, oppressive, coercive and controlling. She concludes by making a rallying call to feminists to refuse conventional cosmetic surgery and proposes its appropriation as a performative protest. Her dystopian agenda advocates the use of cosmetic surgery as a technological tool to revalorise ageing and ugliness. She proposes a gruesome array of possibilities from bleaching hair white, applying wrinkle producing creams and having surgery to increase breast sagging, as a means to destabilising conventional notions of beauty and the power held by cosmetic surgeons. Her recommended protest requires using surgery to achieve a subjective corporeal design, an argument which cosmetic surgeons also appropriate. Unfortunately this is somewhat antithetical to the technological manipulation of the female body against which she so fervently rails.

There are a number of problems with Morgan's (1995) article. Firstly, there is the fact that she did not actually engage women who have had cosmetic surgery and secondly, her conceptualisation of structural and personal power defines women as oppressed, controlled and coerced. Such a model inevitably censors the voices of women who have cosmetic surgery and relegates them to deluded, passive victims of an oppressive cultural system. Furthermore, such an account alienates, silences and 'others' women who undertake cosmetic surgery by making them abject. But perhaps even more seriously, Morgan's (1995) deception in appropriating the voices of those who undertake cosmetic surgery repeats the worst crimes of patriarchy in its violence. Davis (1995) asks similar questions to Morgan (1995) but, because she did engage with women rather than speaking for them, as it appears Morgan does, comes up with a totally different account of women's decisions to undergo surgery.

Davis' (1995) research work was the result of an extensive empirical study in which she conducted face-to-face interviews with women who had undertaken cosmetic surgery. As I found with my own research, directly encountering the distress women feel about their appearance is difficult terrain and face-to-face interaction makes it abundantly clear that neither they, nor the reasons they give for seeking surgery, can be reduced to simplistic models of patriarchal oppression. As a researcher it is deeply confronting to hear excruciating stories of body loathing and today we are no closer to really improving the way

in which women relate to their appearances than Wolf (1991) was nearly two decades ago. A recent survey of some 45,600 young Australians undertaken by Mission Australia (2008) found that body image was the most pressing problem confronting young adults aged 20-24 years. In addition, a recent study by Courtney Martin (2007) confirms that body image dissatisfaction amongst American teenage girls and young women remains a serious social problem which appears to be far from abating. My own study found that being afflicted by poor body image is experienced as deeply personal and shameful, and, consequently, remains hidden. Body image anxiety surrounds us but we have no language to readily discuss it. One must take care with whom one discusses such things. If others were aware they might dismiss it, or you, as ridiculous, vain or afflicted by neurosis. Since those experiencing body loathing cover its presence, it is possible for others to pretend it is not really a problem affecting ordinary women, while safely pathologising those who go to an extreme and become obviously obese, anorexic or hopelessly addicted to cosmetic surgery. Davis' (1995) interviews take her below the surface to confront the wound that is body loathing and, although she struggles to reconcile what she hears with an apparent theoretical disdain of women who engage in cosmetic surgery, she manages to bring understanding and dignity to her respondents' accounts.

Reshaping the Female Body: The Dilemma of Cosmetic Surgery by Davis (1995) was the result of three qualitative studies undertaken in the Netherlands over several years. Like most of the developed world, the Netherlands had experienced an increase in cosmetic surgery, with more people per capita, at the time of her writing, estimated to have undergone surgery than in the U.S. (Davis 1995:5). Unlike the U.S. where cosmetic surgeons advertise to ensure a competitive edge (Sullivan 2000) and the expense of surgery is the patient's own, cosmetic surgery was, at the time of Davis' study, covered by a national health insurance scheme. However, health care expenses were under government scrutiny and cosmetic surgeons were increasingly required to account for the surgeries they performed in ways their counterparts working in deregulated medical systems were not. As the Netherlands was an 'exception,' Davis (1995:7) argued that it was a 'good place to explore the cultural and ideological dynamics of decisions concerning cosmetic surgery,' which may be obscured

when such decisions are affected by consumer choice and the unrestrained economics of market driven medicine.

The first component of Davis' (1995: 7-10) study involved ten in-depth biographical interviews with mostly professional women. She had little trouble enlisting participants through a 'snowball technique' as women approached her when her research topic became known. Her second study was undertaken in the plastic surgery department of a teaching hospital where she was able to contact thirty women who had undergone breast augmentation within the previous five years. Breast augmentation was, at the time, the most frequently performed cosmetic surgery in the Netherlands. In addition, Davis interviewed twelve women prior to surgery and followed them up one year later. Women from this group were white and from lower-middle or working-classes and all but one of their operations were covered by national health insurance. The third part of Davis' study was conducted over a period of eighteen months when she observed consultations between clients and medical inspectors. Medical inspectors were required to approve cosmetic surgery before it could be covered by the national health insurance scheme, but guidelines for the inspectors were vague and they were under pressure to reduce cosmetic surgery expenditure. Through the consultation process both inspector and applicant were required to negotiate whether surgery should proceed with national health insurance cover and to justify their reasoning.

For Davis (1995), as a feminist, the practice of cosmetic surgery was perplexing, highly problematic, and the negotiation of her discomfort is woven throughout her book. Her views about cosmetic surgery were in line with feminist thought and highly critical of cosmetic surgery, but she found them challenged when a feminist friend who, after much soul searching, decided to undergo breast augmentation. Turning to feminist texts to make sense of her friend's decision, Davis was unable to find any theory to explain why a well informed woman, staunchly against the beauty system, would take the surgical option to alleviate the sense of suffering her feelings about her body generated. In reviewing the literature, Davis (1995:57, 58) found a number of problems with feminist theory. Firstly, although feminists have given considerable attention to the masculinist underpinnings of epistemologies of the body, 'women's active and lived accounts seem to disappear in feminist accounts,' making

feminist commentary on cosmetic surgery a 'strangely disembodied phenomenon, devoid of women's experiences' (Davis 1995:57). Here dualistic conceptualisations of the body are reinforced, as cosmetic surgery is seen always as a transformation of the body as an object and never a transformation of the self. Secondly, feminist theory could not acknowledge that the woman embarking on cosmetic surgery was a knowing agent, since those who seek cosmetic surgery were viewed as reproducing compliance with institutional submission. Thirdly, by ignoring those who have cosmetic surgery, feminist interventions into cosmetic surgery become restricted to moralising treatises about the acceptance of a range of body types, without gaining potentially valuable insights into the reasons why women undertake cosmetic surgery, or the ways in which cosmetic surgery is problematic to those who choose to have it. Davis concludes:

While contemporary feminist scholarship has made a strong case for linking beauty to an analysis of femininity and power, it has been less successful in finding ways to understand women's lived experiences with their bodies, how they actually decide to have cosmetic surgery and how they access their actions after the fact (1995:58).

Davis (1995) found women who have cosmetic surgery are no more concerned about their appearance than other women. They undergo cosmetic surgery, not to become beautiful but, rather, to become ordinary or normal. Their accounts illustrate how dissatisfaction with physical appearance can 'generate a biographical trajectory of suffering' (Davis 1995:161) which has a devastating impact on the sense of self, similar to that of chronic, debilitating illness. Cosmetic surgery, she found, was embraced as a strategy to alleviate unbearable suffering. It presented an opportunity for the individual 'to renegotiate her relationship to her body and through her body the world around her,' ironically, cosmetic surgery offered an opportunity for women to become more comfortable with their bodies 'as embodied subjects rather than objectified bodies' (Davis 1995:161). Contrary to popular belief, her interviewees insisted that their decisions to have surgery were their own: none felt pressured by partners or coercive surgeons. Many had taken the steps to have surgery against the advice of those around them, and were elated to have actually made the decision. For many it was the first time they had done something completely for themselves and their stories

were retold as 'heroic tales' where they confronted not only their own fears, but the resistance of others. The majority of her participants were pleased with the outcomes of their surgery, even when surgery induced pain, failed to meet expectation or was disfiguring. In such instances participants accepted their responsibility in taking the decision to have surgery. In reflecting upon their experiences, few had regrets about having surgery and most claimed they would do it again. For these women the step to have surgery was not lightly taken. Many were critical of a beauty system which had forced them to undertake an extreme measure such as cosmetic surgery, and most believed that cosmetic surgery should not be seen as a popular solution for the problems women have with their appearance and should be done only in extreme cases. Their rationales for surgery were often couched in the concept of justice, articulated as 'rights,' 'rights' enacted in response to an unjust social order: 'the right not to suffer, the right to a reasonable degree of happiness or well-being, or the right to take advantage of available services or technologies ... The right to do with her body as she will' (Davis1995:163). Davis (1995, 2003) has consistently argued cosmetic surgery has less to do with beauty and more to do with identity. In 1995 she wrote:

Cosmetic surgery is not about beauty but about identity. For a woman who feels trapped in a body which does not fit her sense of who she is, cosmetic surgery becomes a way to negotiate her identity through her body. Cosmetic surgery is about exercising power under conditions which are not of one's own making. In a context of limited possibilities for action, cosmetic surgery can be a way for an individual to give shape to her life by reshaping her body. Cosmetic surgery is about morality. For a woman whose suffering has gone beyond a certain point, cosmetic surgery can be a matter of justice - the only fair thing to do (1995:163).

Davis is an empathic researcher and clearly committed to taking the accounts of those whom she interviewed seriously. However, while not discounting the suffering her participants recount, I do question the context of its emergence. Davis' research was done largely from within the medical system. To be successfully approved for surgery applicants had to convince a medical inspector that the impact of their perceived impairment was so extreme that surgery was warranted. Within such a context the demonstration of suffering becomes an institutional requirement, of which applicants would have been acutely aware, since three consultations were mandated before surgery was approved (Davis 1995). Do these

requirements then come to structure how women think about their appearance? Is it not possible that patients, either subconsciously or consciously, as an act of impression management, embellish their 'trajectories of suffering' as a way of ensuring that their applications are approved; is it not possible then that their own biographies, their own self-talk or soliloquy, repeated and practiced, become shaped by institutional demand? Davis herself does not question the role which institutional imperative might impose on structuring her participants' narratives and this omission has left her study vulnerable to criticism (see Holliday and Sanchez-Taylor 2006:188). Nor does she address how the women came to formulate their ideas about their appearance, or consider wider issues such as why women are so dissatisfied with their body's appearance. While Davis is not unaware of the wider structures of gender inequality impacting women, she tends to put them to one side and focus on the women as agents, thus individualising the problem of female identity (Negrin 2002).

Davis' (1995) refusal to treat her participants as the duped victims of an oppressive beauty regime is unquestionably ethical, but defending her research findings has come at some cost and seen her feminist credentials questioned. Her academic peers have had difficulty accepting her findings (see Davis 1995, Chapter Seven). In keeping with the personal reflexivity demonstrated throughout her book Davis questions her analysis and wonders whether she has gone too far and fallen into the anthropological trap of 'going native.' She asks whether it might be 'possible to listen to the same stories and yet come up with a very different reading' (Davis 1995:164). She reassesses her own findings and does a comparative analysis to the article written by Morgan (1995) discussed earlier. All the while Davis is attempting to uncover why her research has evoked such a negative response from her feminist peers. At a conference where she and Morgan both presented papers, her presentation aroused palpable discomfort, blank expressions, murmurings and hostile questions. Morgan's paper, which Morgan introduced with an anecdote recalling meeting with a wealthy, suburban, surgically enhanced woman whom she likened to a 'Stepford Wife,' was, on the other hand, positively received (Davis 1995:175). Davis believes 'political correctness' is permeating feminist ranks and Morgan's views are representative of a correct political position that makes it easier for feminists

to take a clear stand against cosmetic surgery as oppression, normalization and ideological manipulation. It provides a way to denounce women's victimization without having to condone their own participation in it. Its adherents can tighten their ranks in a collective dismissal of cosmetic surgery and in an abstract solidarity with women as victims of medical technologies and cultural discourses. They also share distance from those less deserving of their sympathy: the wealthy, white, heterosexual or embarrassingly addicted. Having established a position, they know what they are up against and can exclude anything which detracts from or dilutes their critique (Davis 1995:179)

Another qualitative study undertaken by the sociologist Debra Gimlin (2002) explored how American women use appearance related technologies to forge individual identities. On the subject of cosmetic surgery several of Gimlin's findings supported those made by Davis (1995). Gimlin's participants, in line with those Davis interviewed, nominated cosmetic surgery as the last resort available to alleviate the torment of a despised bodily feature; they reported engaging cosmetic surgery in an attempt to feel 'normal' rather than to become beautiful and they denied any coercion to have cosmetic surgery by a masculine other. On this occasion Gimlin appears to tread carefully in her analysis. She views her participant's surgical ventures as 'misguided' (2002: 107) and argues they must defend their surgeries whilst making it very clear that she is in no way defending cosmetic surgery as a choice. In view of the subsequent criticism Davis' work generated, Gimlin's caution is perhaps unsurprising.

Gimlin's (2007) more recent work, which examined the differences between British and American women's accounts of cosmetic surgery, found the British women she interviewed more readily nominated a husband or partner's criticism of their appearance as informing their decision to have cosmetic surgery than the American women she interviewed. In addition the British women were more likely to be secretive about having surgery. Gimlin explained these differences in terms of health care culture since the privatised health care system in the US enshrines individualism and health care as a consumable service for those wealthy enough to afford it, whereas in Britain health care is considered a right and available to all. Gimlin (2007:48) states her 'principle theme' of research was 'women's motivations for having cosmetic surgery' but one of her enduring interests is the way in which women

'justify' or 'defend' (Gimlin 2000; 2007:51) their surgeries, terms which invariably distance women who have cosmetic surgery, and the bodily dissatisfactions which impel, them from others in the population. At a time when appearance dissatisfaction and the implementation of cosmetic surgery are dramatically increasing, such a position risks limiting the way in which the motivations of those undertaking cosmetic surgery might be explored.

While feminist research has been instrumental in problematising the body and bringing it to the fore as a legitimate site of academic research, cosmetic surgery remains deeply problematic to feminists, and indeed many social scientists. To date the research methods adopted by feminists to explore cosmetic surgery have favoured the discourse analysis of texts relating to cosmetic surgery or the textual analysis of media products which discuss or represent cosmetic surgery (see for example Sullivan 2000, Woodstock 2001, Fraser 2001, Fraser 2003, Heyes 2007, Pitts-Taylor 2007, Jones 2004, Jones 2008a, Jones 2008b). On occasion a small qualitative component has been integrated into such forms of analysis (for example see Pitts- Taylor 2007 and Jones 2008a) but it is more often utilised to augment an argument rather than providing the starting point of analysis. While diversity in scholarship can only add depth to the growing body of work on cosmetic surgery, the comparative lack of in-depth, interview-based, qualitative research needs to be addressed. At the time of writing there had been few qualitative studies done from an exclusively feminist standpoint other than Davis' (1995) and in view of the interest her work has generated it remains significant to any discussion on cosmetic surgery and to any qualitative venture in particular.

Feminists rightly have concerns about cosmetic surgery but in choosing to examine media products and texts about cosmetic surgery they invariably distance themselves from those who undergo cosmetic surgery in ways that qualitative researchers are unable to avoid. Engaging a qualitative study requires researchers work within the confines of the themes their fieldwork generates, and bodily dissatisfaction, in my own experience at least, is a difficult subject upon which to have one's thoughts directed over an extended period of time. Davis' (1995) study in particular gave her unprecedented and extraordinary access to people seeking cosmetic surgery. What she observed and heard was confronting. Her quest to find theoretical guidance from feminist texts to explain her empirical findings was challenging.

Having spent many years immersed in my own participants' accounts, steeped too in body loathing and, like Davis, struggling to find plausible theory to explain it, I came to understand something of her dilemma. With Davis I began my study with an overarching desire to understand what shapes the decisions of those who undertake cosmetic surgery and, with her, I share a commitment to take the accounts of my participants seriously and extend to them the respect they rightly deserve. With a general grounding in sociology, a central goal of the current study was to explore the underlying social contexts in which the motivation to proceed with surgery becomes imperative. From its inception a particular interest of this study was to examine the ways in which interaction with significant others informs the subjective experience of embodiment. As the study proceeded it became clear that participants experienced their bodies as something which is learned, interpreted and attributed particular value through such interaction. Social interaction emerged as centrally important to the formation of body image and its subsequent amendment with cosmetic surgery.

My own study was drawn from 31 face-to-face, in-depth interviews, each lasting between one and three hours. Recruitment for this study did not specify a preference for respondents based on their sex, but because only one man presented to participate his interview was removed and the study became focused specifically on the experiences of women. Of the final 30 participants, 26 had already undergone cosmetic surgery, 2 were booked to have cosmetic surgery and 2 women who expressed an interest in participating in the study were also interviewed. These latter women were particularly interested in the relationship between body image and work. Both had had dealings with others who had undertaken cosmetic surgery which had initiated their own considered thought regarding the role cosmetic surgery might play in the lives of working women. Conversations I engaged in while undertaking this study, as well as the experiences of acquaintances and friends, have been woven into the account that follows. I include their comments because, in the course of undertaking this project, 'makeover television' brought cosmetic surgery into the living rooms of the viewing public and stimulated a general discussion in which body image and cosmetic surgery emerged as keenly discussed topics of conversation.

Recruiting participants for the present study

Participants were sought who were either booked to have or had undertaken cosmetic surgery within the past ten years. I was particularly interested in cosmetic surgery because the need for general anesthesia, the recovery time required and the expense involved make it a much more serious proposition than a cosmetic procedure which might take minutes in a doctor's surgery. Cosmetic surgery was simply defined as an elective surgery, unrelated to a medical condition, undertaken with a view to aesthetically improving appearance. This delineation between aesthetic and medically beneficial surgery was not always entirely clear since participants did speak of the form and function of their bodies as interrelated on occasions. However, participants understood that their aesthetic motivations in seeking cosmetic surgery were a central focus of this study.

Despite this study being conducted during a period when cosmetic surgery entered the mainstream, recruiting for this study was difficult. Information sheets describing the study and inviting people to participate were distributed to beauticians, hairdressing salons and doctors surgeries in a small Tasmanian city. This proved to be the least successful route taken to recruit participants since only two women came forward in response to reading an information sheet accessed from one of those settings. Five women with whom I was already acquainted presented for interview when they became aware I was conducting the study. Friends, colleagues and acquaintances volunteered as gatekeepers, passing on information sheets, and slowly the number of participants grew. Twelve participants presented via this route. A press release about the project generated considerable interest. As a result I was interviewed to discuss the study and subsequent articles appeared in a national broadsheet and local newspapers. I was also interviewed by a representative from a radio station with national coverage and a local television station ran a small story about the research. In addition, an advertisement calling for participants was placed in a Tasmanian newspaper. Seven participants presented after hearing or reading about the research from one of the latter sources and another three participants presented via 'snowball' from this group. Although I was based in Hobart during the course of the project, having access to nationally based media organisations opened up recruitment to a broad range of participants from across Australia.

This study had ethics approval from the University of Tasmania Ethics Committee and a copy of the Information Sheet distributed for the study is contained in the appendix.

The participants' ages ranged from 19 to 67 years with the average age of all participants being 48.5 years. The majority of the women were employed in the service sector delivering a range of services from semi-skilled to highly specialised. Five women owned or managed small businesses. Five women described themselves as exclusively retired and four described themselves as students. Of the 28 participants who had had cosmetic surgery or were booked to have cosmetic surgery, 26 had attended some form of college training and 10 were either attending university or held a university degree. It was never an interest of this study to fragment the body into parts upon which particular surgeries had been performed (medicine does that well enough) but because those who express interest in the study frequently ask, I have grouped the types of surgeries participants engaged in below:

- 10 of 28 (36%) had more than one surgical event relating to body modification
- 20 of 28 (71%) had surgery to their bodies
- 11 of 28 (39%) had facial or facial and neck surgery
- 2 of 28 had surgery to both face and body
- 3 of 28 had breast augmentation
- 15 of 28 (53%) surgeries performed, or booked, related to weight loss or pregnancy
- 3 of 28 had weight loss surgery prior to having, or considering, cosmetic surgery
- 8 of 28 (29%) had surgery to reduce or lift breasts

The interviews with the participants were initially recorded, then transcribed and analysed for major themes. Participants were offered the opportunity to read their transcript but only one requested that option. Like Davis (1995) I found myself somewhat dismayed at the dearth of theoretical material which came close to explaining the themes emerging from my participants' accounts. I had expected to find a degree of pragmatism in the motivations of those who seek cosmetic surgery and whilst this was the case in some accounts, it was the unremitting loathing in participants' description of their pre-surgical bodies which I found overwhelming. As the interviews progressed I found myself unable to account for the

emotional distress that such loathing causes, a distress not dissimilar to what Davis (1995) observed, in the literature on the body that I had read.

As I analysed the first of the interviews it became clear that participants were not actually discussing their bodies: rather, they were speaking about a more specific relationship between self and body image to which evaluative measures and assessments had been applied. They described particular ritualised processes that were intimately enacted in the pre-surgical phase when their bodies were assessed as no longer appearing acceptable. These processes occurred somewhere on the cusp between the front and back stages which Goffman (1974) delineated. Spatially such a zone would technically be described as backstage since it is within the privacy of the home, in a bedroom or bathroom or wherever there is a mirror, that such an evaluation takes place, but temporally and psychologically the self is imaging itself in the future and in the social world. Projecting itself ahead in time, and evaluating how the present self will appear, the self questions whether it will be accepted or not. Neither backstage nor front stage, it is an interstice which interfaces the private and public domain, a transitional zone where the backstage, private self assesses, rehearses, constructs and envisages an imaginary prototype of its front stage self. In such a zone the self is simultaneously private and social. Cooley (1964:184) recognised these processes in his formulation of the 'looking glass self' and in many ways this study, by expanding upon and developing themes found in participants' accounts, develops his observations. The following chapter begins by outlining the challenges I encountered in speaking to participants about their appearance and then explores body image through the contributions made by psychoanalysts, before returning to consider the way in which participants spoke about their body's appearance prior to initiating cosmetic surgery.

Chapter Three: The Mirrored Self

On the dust jacket of Victoria Blum's exploration of cosmetic surgery in America, *Flesh Wounds: The Culture of Cosmetic Surgery* (2003), feminist fiction writer Fay Weldon begins her endorsement of Blum's book with an astute comment: "I blame mirrors. If it weren't for them we wouldn't need plastic surgeons." Despite their ubiquity, it is only within the past century that industrialised processes of sheet glass production and silvering have seen mirrors colonise domestic surfaces and urban landscapes, presenting modern selves with inescapable and frequently uneasy relationships with their own reflections. Weldon herself is the author of *The Life and Loves of a She Devil* (1983) a modern fable in which the plain protagonist, Ruth, incensed by her husband's infidelity with a petite romance writer, uses cosmetic surgery to transform her bulky form into a replica of her rival to ultimately assume her identity and savagely avenge the betrayal. As Ruth's story unfolds we are left in little doubt that her life has been defined by her appearance. Her plainness has been used to legitimise her rejection by those closest to her. Firstly her parents and now her husband have discarded her, extinguishing her very right to participate in their lives. Mirrors, however, are not the only reflectors of Ruth's self-worth, it is the reflections of those who are closest to her that inform her and relegate her to the realms of abjection. In a parting rant her husband exonerates himself of any responsibility for the demise of their marriage and his desire to seek the affections of another. He levels all blame at Ruth and accuses her of being other than human, a she devil. In this moment of extreme rejection Ruth realises that while she is powerless to change the world, she can change herself. Life's scrapheap is not to be her destination and Ruth initiates a brutal restitution. She forces her self-centred nemesis to account for her injustices by employing cosmetic surgery to gradually morph into a replica of her petite form. Following her foe's eventual death, Ruth finally resumes her place beside her husband, now dazed and emasculated by the chain of events unleashed by his stirring of Ruth's wrath. Weldon's fiction is essentially a feminist fairy tale in which the beauty system, the way it is sustained and replicated, and the unjust hierarchies embedded within it are brought into heightened focus. For Ruth, undergoing cosmetic transformation is not about becoming beautiful; beauty in and of itself is of little interest and brings her no enjoyment. For her, beauty is power. Weldon gives a provocative reading of cosmetic surgery and the

beauty system and while her comment on Blum's book regarding mirrors is simply stated, it is nonetheless keenly observed. Mirrors have become an entrenched aspect of modern architecture, delivering the ultimate tool of self-surveillance and invariably changing the ways in which we have all come to view ourselves.

When I started interviewing for this study it immediately became clear that it was difficult for participants to speak about how they felt about their appearance, particularly prior to having surgery. I presumed from the outset that the desire to change one's appearance must emerge from dissatisfaction with it. I quickly realised that it was difficult for participants to respond to such a direct line of enquiry. Rather than asking directly about feelings aroused by appearance, I found it a much more fruitful question to ask the participants how they had felt when they saw themselves reflected in a mirror. Indeed, in the same way that mirrors mediate our view of ourselves, mirrors also mediate and facilitate personal discussion about appearance. I found that asking participants to recall the feelings evoked by looking at themselves in a mirror stimulated a discussion about appearance much more effectively than questions relating directly to feelings about appearance. At the time I did the interviews, my concern was to facilitate a discussion, to encourage the interviewees in speaking informally and comfortably about what shaped their decisions to seek surgery. I was acutely aware that such a line of enquiry might venture into highly personal and, as I was to find, highly sensitive aspects of personal narrative. It was therefore in the interests of both myself, as the convener of the interview, and the respondents, to make the interview 'space' conducive to conversational flow. As I analysed the interviews I came to understand that framing questions around feelings associated with negotiating appearance raised a number of theoretical questions about how body image is developed. It also became increasingly clear that notional ideas of the self and body image merge and separate continuously and can, in given situations, be two entirely different things. Moreover, mirrors, as the ultimate modern tool of self-surveillance and evaluation, are instrumental to that process.

Reflective surfaces have long held the fascination of developing humanity, but it has only been within the last century that the development of industrialised processes and changing domestic architecture have seen mirrors proliferate in both public and private spaces. In his

history of the mirror, Prendergrast (2003) traces the technological development of the earliest reflective surfaces, from black obsidian hand polished by Stone Age hunter-gatherers in Turkey around 6200 BC, through simple reflective metal surfaces made from copper and bronze, to the mass production of sheet glass in the period from 1850 until 1950. Industrial manufacture of the earliest mirrors was a dangerous and expensive enterprise and, as a consequence, mirrors were only to be found in the homes of the wealthy or selected public places. A revolutionary method of spraying silver onto the back of glass sheets was developed in the 1940s which vastly reduced the volatility of earlier manufacturing processes and paved the way for the mass production of mirrors. Subsequent reductions in expense saw mirrors increase both in size and ubiquity within evolving modern architecture, to take their place in the increasingly privatised space afforded by the bathrooms and bedrooms so readily embraced by the middle and aspiring working-classes. This provided a fascinated population unprecedented opportunity to intimately examine themselves within the privacy of their own homes. One can speculate that the relatively recent proliferation of mirrors, modifications in domestic architecture and the concomitant rise in visual culture, with its evident privileging of youth and beauty, have all contributed to a steadily increasing self-consciousness and subsequent anxiety around the body, which, according to sociologist Norbert Elias (1978, 1982), has slowly evolved over many centuries within Western culture. One could further speculate, as indeed Weldon does (on Blum 2003), whether the subsequent rise in cosmetic surgery and, indeed, the ever-expanding plastic arts of self-production more generally, would have occurred without the installation of mirrors into the inner sanctums of private life.

Mirrors provide visual access to the external appearance of the body. As Hepworth (2000) observes, viewing oneself in the mirror is a personal act informed with social meaning, but he also notes that it is a mediated representation of one's self-image which is reflected back, a view of the self that is, in effect, a flattened and immobile image:

Looking into the mirror is an interactive process through which connections are made between the personal subjective self of the viewer and the external world of other people. Because we have no direct access to the external reality of the body, even with the assistance of aids such as

mirrors and the wide range of technical apparatus now available (cameras, video cameras and the like), the act of human perception is always mediated symbolically by meaning. When we look into the mirror we are therefore engaged in an act of the imagination whereby the self is constructed symbolically as a portrait or a picture (Hepworth 2000:46).

By observing that the image reflected back from the mirror is frozen in the moment, Hepworth (2000) touches on the illusionary and deceptive nature of the mirrored image. Yet much may be invested in how this image is integrated into notional ideas of the self.

Participating in a project on cosmetic surgery, I found myself frequently engaged in conversations, always with women, who, upon learning about my research project, were keen to discuss what has become a hot topic of conversation. Makeover programmes which advertise and normalise cosmetic surgery have, in the early years of this century, been aired on Australian television for the first time. Their impact upon the complex and rapidly changing formulation of cosmetic surgery has generated recent academic interest (see for example Heyes 2007, Pitts-Taylor 2007, Wegenstein 2007, Jones 2008a, Jones 2008b). The makeover format invariably follows a selected participant through a number of surgeries, dental work, fashion makeovers and tailored exercise regimes to 'reveal' said participant several weeks later to a gathering of friends and relatives, in an extravagant display of the transformative possibilities of modern grooming technologies. Testimonials of participants promote the idea that the lives of 'ordinary people' (as opposed to celebrities and the wealthy) can be transformed by cosmetically enhancing the body. Hard working female viewers are encouraged to think of cosmetic surgery as a reward they deserve because they have sacrificed their bodies for their children, families, and even careers. While the sacrifice itself is lauded, the reward of surgery promotes the removal of the bodily inscription which leaves evidence of the sacrifice. By emphasising sacrifice and reward the old taint of vanity is obfuscated in the mediated construct of cosmetic surgery.

In my own anecdotal experience, newly initiated viewers to the mediatised cosmetic surgery makeover appeared to swing between being appalled or excited by the newest surgical technique lavishly demonstrated in this form of programming. However, those who

participated in this study tended to be less than impressed. Many reported having been curious enough to watch some episodes of *Extreme Makeover* when it first aired, but the majority of participants found the programme content to be sensationalist, unrealistic and frequently offensive to women. A few participants spoke of watching similar types of programmes on occasion, but only one claimed to enjoy *Extreme Makeover* and watch it regularly. Despite the ambivalence of participants in this study, programmes featuring cosmetic surgery makeovers have been highly effective in stimulating an interest in cosmetic surgery. Cosmetic surgeons with whom I spoke, and media articles discussing cosmetic surgery's increasing popularity, frequently report that wherever such programming has aired a marked increase in both enquiries and those presenting for cosmetic surgery has followed. Consequently, it was not unusual to find myself in conversation with complete strangers or casual acquaintances who were keen to talk about cosmetic surgery. Typically, part way through a discussion, my conversant would drop her voice and adopt a confessional tone. She would begin by saying she had never supported the idea of cosmetic surgery but now, as she pointed to a disliked facial feature, she found herself considering it. Initially disconcerting, these encounters had the effect of pulling my attention away from the whole face and body, animated in the act of conversation, to share in the intimate view of a perceived flaw which my conversant saw motionless in front of the mirror. Invariably I had not noticed the 'flaw,' but gradually I began to understand that there is a visual discrepancy between the face and body as seen in the private act of inspection in front of the mirror and the very different view, seen by another, when they are engaged in conversation. Mobile and animated, the face and body are inherently more complex and expressive than the image of the self which is flattened and framed by a mirror. Such conversations were instructive since they brought into focus the discrepancy between the subjective view of the external appearance informed by reflection and their imagined view of the way their appearance might be seen by others. In the next section I explore the relationship between the self and body image and how it has been articulated through the academic literature. 'Self' and 'subject' are used interchangeably as the self is transformed linguistically to a subject when it speaks about itself.

Constructing body image

In *The Image and Appearance of the Human Body: Studies in the Constructive Energies of the Psyche* first published in 1935, German writer Paul Schilder (1950) explores what constitutes body image and how one's own body image comes to be formulated by the self. Schilder proposed that the normal construction of one's own body image is dependant upon the integration of life experience, which incorporates knowledge acquired by the body spatially and temporally, both consciously and unconsciously, through physiological, psychological and sociological processes. From his introductory remarks it is clear that Schilder's concern is with the relationship between the self and the meanings the self attributes to its own body image:

The image of the human body means the picture which we form in our mind, that is to say the way in which the body appears to ourselves. There are sensations which are given to us. We see parts of the body surface. We have tactile, thermal, pain impressions. There are sensations coming from the muscles and their sheaths ... and sensations coming from the viscera. Beyond that there is the immediate experience that there is a unity of the body. The unity is perceived, yet it is more than perception. We call it a schema of our body or bodily schema, or, following Head, who emphasizes the importance of the knowledge of the position of the body, postural model of the body. The body schema is a tri-dimensional image everyone has about himself. We may call it body image. The term indicates we are not dealing with mere sensation or imagination. There is a self-appearance of the body (Schilder 1950:11).

Schilder (1950) studied neuroscience, psychiatry and psychoanalysis and was influenced by the contemporary work of Freud, yet he theorises body image as a complex phenomena emerging from a decidedly psychosocial perspective. His study of body image focuses on the physiological, libidinal (or emotional) and social structures underpinning the construction of body image. For Schilder, body image and bodily function are materially experienced, interpreted and acted upon within multifarious matrices imbued and interwoven heuristically between the psychosomatic realms of personal and social experience. Body image is the interface between the inner world of subjective experience and the outer environment of objects and social life. Body image is the medium through which we come to think of ourselves as embodied social selves. Moreover, its construction is an ongoing and fluid

process which is configured and reconfigured in embodied interaction throughout the life course. For Schilder, body image is built up through the practice of 'structuralization,' a concept which designates the acquisition of body image as both process and structure. Body image is not automatically given but is achieved by physiological projection; it evolves from accumulated knowledge initiated by spatial orientation, movement and encountering external objects and their surfaces:

By movement we come to a definite relation to the outside world and to objects, and only in contact with this outside world are we able to correlate the diverse impressions concerning our own body. The knowledge of our own body is to a great extent dependant on our action ... we acquire it [body image] in the direct and intentional action concerning the world. ... It is a creation and a construction and not a gift. It is not a shape ... but the production of a shape. There is no doubt that this process of structuralization is only possible in close contact with experiences concerning the world (Schilder 1950:112, 113).

Continual action is central to the experience of bodily selves and it is through movement that we come to orientate ourselves as embodied social entities with an understanding of the capacities and limitations of our bodies. Bodily action is always directed towards an object whether it is one's own body or an object external to the body (Schilder 1950:51). Through body image we orientate ourselves to an external world of objects, although this, as Schilder goes to considerable lengths to emphasise, is not always easily achieved since the boundary between the body and external objects is never clearly defined. We make decisions and choices, defining the parameters of our social worlds, accepting and rejecting through physiological action (Schilder 1950:105). Within this medium of interchange between body and surrounding environment, 'the body will be projected into the world, and the world will be introjected into the body' (Schilder 1950:123). Through empirical studies, visual capacity and its attendant importance in structuring body image is noted. Furthermore Schilder (1950:125) suggests that it is through visual receptivity that the symbolic world is introjected or unconsciously internalised.

Within psychoanalysis the concepts of introjection and projection have particular meanings relating to the earliest oral stages of developmental where the infant determines whether

objects are edible or non-edible through oral differentiation. Introjection relates to acceptance by swallowing and projection refers to rejection or spitting out. In adults, introjection and incorporation are frequently used interchangeably to describe the processes employed to achieve identification. Identification refers to a state rather than a process which describes the relationship of the self/subject to objects (Blum 1953b:47). Introjection is the opposing process of projection and was first introduced by Ferenczi, a contemporary of Freud's, in 1909. Introjection refers to the way in which the subject, through imaginary processes or fantasy, takes objects from the outer world and incorporates or integrates them as part of the inner world of the self (Diamond 1992:176,177). Socialisation processes which integrate firstly parental, and later societal, prohibition can be attributed to the process of introjection. Freud describes the way in which the developing child unconsciously takes on firstly parental and subsequently societal values, or the superego, as occurring through the process of introjection. Moreover, it is through the mechanism of the introjection of the superego, that Freud sought to understand the self-evaluation and monitoring mechanisms underpinning the moral structures of the individual (Storr 1989). Diamond (1992:177) goes further in her definition to suggest that processes of introjection have been underutilised by feminists in explaining how women construct images of themselves. Introjection, she contends, can explain why women feel alienated from their own images and consequently 'objectified in relation to themselves,' and why they frequently feel left with a sense of 'lack' in relation to men (Diamond 1992:177). She posits that this may occur because women construct their own self-images by the introjection and assimilation of images of women which are projections of masculine fantasy. Weldon (1983) exploits this phenomenon through her protagonist, Ruth, with her calculated and obsessive surgical transformation into the image of the woman who has stolen her husband, but any explanation of Ruth's motivation is left unexplained.

Bodily boundaries blurred

As one finds with Freud, a metaphoric subtext of the body as a perforated but sensate container regulated at the margins flows through Schilder's (1950) exploration of body image. Here the orifices of the body, the points at which exchange with the outside world are the most obvious, are accorded particular significance. Schilder (1950:124,125) notes the

enormous importance of the bodily orifices as locations on the surface of the body where exchange with the external world occurs, the portals through which inner organs direct and organise social contact.

It is in the pre-oedipal and formative linguistic stage that infants and young children initially come to learn about their bodies and how they function through tactility, gesture and vocal tone. Although grooming practices most certainly incorporate elements of display, at a most basic level the grooming of small children is undertaken to sustain physiological integrity, to avoid the inevitable irritations that neglected skin, orifices and internal organs will elicit. Apart from the more obvious nutritive and hygienic functions of grooming, the grooming of infants and small children is also a pedagogical activity wherein children are taught the social meanings, responsibilities and expectations that embodied subjectivity entails. For now it is sufficient to note that the intimate attention directed towards the body through care is not a neutral activity. It may also affirm, or otherwise, feelings of self-worth. Schilder contends that early socialisation processes are integral to the ongoing process of constructing body image:

[Body image] is built up not only by the interest we ourselves have in our own body, but also by the interest other persons show in the different parts of our body. They may show their interest by actions or merely by words and attitudes. But what persons around us do with their own bodies is also of enormous importance. Here is the first hint that the body image is built up by social contact. ... The building-up of the body image is based not only upon the individual history of an individual, but also in his relations to others. The inner history is also the history of our relations to other human beings (Schilder 1950:137,138).

Schilder's observations are highly relevant to this study. Over half the participants in this study (16 of 28) described the relationship between self and body image as complex, difficult, emotionally fraught and part of an ongoing negotiation that emerged from within intra-familial interaction with parents, siblings and partners, or close relationships with friends. In fact, the group of participants as a whole could be divided into those for whom bodily appearance was a recent concern and those for whom having the most recent cosmetic surgery was simply the latest in a series of ongoing interventions enacted to resolve

dissatisfaction with bodily appearance or an aspect of bodily appearance. Such interventions included previous cosmetic surgery, surgical weight-loss procedures such as laparoscopic banding or intermittent dieting.

Through a series of experiments, Schilder (1950) sought to determine how we come to formulate bodily image on a sensory level. Focussing on visual perception and tactility he compared how body image is interpreted in these two sensory ways. In a study of autoscopia (seeing one's self) Schilder (1950:84) found that when asked to imagine themselves with their eyes closed, those he studied tended to describe their body image as a flattened, static representation of the outer surface of their own body, much like a mirrored image or the picture Hepworth (2000) refers to, although somewhat smaller. Visual imagery of the body, whether imaginatively or in reflection, presents the body as a clearly bounded, spatial entity. On the other hand, when the capacity to visually confirm the margins of the body is removed, and tactile perception alone is deployed to interpret body image, the outer surface of the body is perceived with most certainty where the surface of the body directly encounters external objects. An example here might be sitting in a chair, where one is aware of the bodily surface most clearly where the surfaces of the chair touch the body along the back and the back of the legs. A similar discrepancy was observed between where the orifices of the body are located visually and where they are actually described as felt by the individual; usually a few centimetres proximal to the spatial boundary of the body. Schilder found that the surface of the body becomes increasingly less well defined without visual confirmation of its outline. He notes:

A more careful analysis about what is felt on the skin immediately reveals astonishing results. There are vague feelings of temperature. It is more or less the feelings of warmth. But the outline of the skin is not felt as a smooth and straight surface. The outline is blurred. There are no sharp borderlines between the outside world and the body (Schilder 1950:85).

Furthermore, it is when we touch our own bodies with our hands that tactile sensation and visual perception of bodily form come into alignment along the surfaces which are brought into direct contact by touch. Questions of what constitutes body image, how it is perceived and where its margins may be located are explored by Schilder (1950) directly and

pragmatically at the level of the material body. Through a range of different postures, environments, states of wellness and levels of intoxication Schilder illustrates how the self's version of its own body image is subject to continual variation. His example of the experience of localised and generalised pain is illustrative. In the event of the latter, self and body undergo a cognitive and perceptual separation similar to the separation articulated by those who took part in this study in their evaluative assessments of body image made in the period leading up to undertaking cosmetic surgery. As Schilder describes it,

The part of the body in which the pain is felt gets all the attention. Libido is concentrated on it (Freud) and the other parts of the body-image lose in importance; but at the same time the painful part of the body becomes isolated. There is a tendency to push it out of the body-image. When the whole body is filled with pain, we try to get rid of the whole body. We take a stand outside our body and watch ourselves (Schilder 1950:104).

The body in pain is rejected when its confines become intolerable as the mind, now a disembodied other, distances itself from its uninhabitable flesh. The notion of a unified self, body and mind harmoniously integrated may, if Schilder's proposal is considered, be more accurately described an elusive and transitory state which only occurs when the body is unproblematically subjected to the will of the mind, thus providing the mind with few obstacles in achieving its desired projections. Put another way, we become conscious of our body through limitation, when there is a discrepancy between desire and the physiological capacity available in any given situation. For Schilder (1950:165) the notion of a cohesive bodily unity is decidedly overrated. This is made all the more clear in the dark and disturbed psychological landscapes inhabited by his patients where the body is experienced as fragmented, dispersed and dismembered. He does not, however, limit his observations to those whose conditions might be considered pathological:

The important conclusion we may draw is that feeling our body intact is not a matter of course. It is an effect of self-love. When destructive tendencies go on, the body is spread all over the world. The correctness of this conclusion may be doubted. One would like to say that we lose the unity of the body only under special pathological conditions; but we also have to remember how much the feeling of our body varies under normal conditions. When we touch an object

with the end of a stick we feel the end of the stick. We feel that clothes eventually become part of ourselves. We build the picture of our body up again and again ... There are forces of hatred scattering the picture of our own body and forces of love putting it together (Schilder 1950:166).

Clearly for Schilder (1950) a sense of bodily unity which reconciles the self and its bodily image is unambiguously connected to how positively one feels about their body. Emotions and emotional attitudes are linked intrinsically to the surface of the body. Libidinal or emotional structures underpin his construction. From the outset Schilder (1950:15) notes that people are emotional beings who have strong feelings vested in their bodies, and the topography of the body in particular has a direct link to this emotional basis. It is through the concept of narcissism or 'self-love' that Schilder connects the normative achievement of developing a separate identity and the subsequent narcissistic investment towards body image that ensues as a result of this process occurring. Although he is less clear in articulating how this process is achieved, what Schilder does offer is a way to understand body image as an object of narcissistic investment occurring at a personal level, but necessarily located within a wider social process of orienting the self into a social world of objects:

What is the relation of narcissism to the image of the body? No libido or energy of the desires of the ego can be present unless there is an object with which they are connected. We are in a world, and objects are part of this world. When we live we are directed to this world ... Freud himself refers to the 'Triebrepsentanten,' the representations which are necessary for the instincts. We have therefore always to ask "What is the object towards which the instinct is directed?" The narcissistic libido has as its object the image of the body. But there is no question that our body can exist only as a part of the world ... Body and world are experiences which are correlated with each other. One is not possible without the other (Schilder 1950:122,123).

Again, these insights are highly pertinent to the current study where discussions of pre-surgical body image were characterised by a range of articulations, from unambiguous disdain for body image through to self-improvement. Cosmetic surgery was almost always embraced and undertaken by the participants in this study as a positive intervention, as an act

of 'self-love,' as an act of caring for and improving body image, firstly for the self and then others. However, there was also a strong correlation between dislike of body image, the amount of surgery undertaken and the complexity of intimate and social relationships. Those who described the most complex social situations also appeared to have been the most fragile or vulnerable before having cosmetic surgery, and had, not insignificantly, undergone the most surgeries. For these women, rebuilding body image through investment in the body's surface was a way of rebuilding identity in the aftermath of rejection or, to use the framework of narcissism, to resolve separation and re-establish a coherent sense of identity through investment in the ego. The ego, Freud (1923:126) reminds us, is always a 'bodily ego' or a screen or surface onto which the meanings which the subject itself attributes to its own body are projected (Grosz 1992:37).

Schilder (1950) rightly links social interaction to the construction of bodily image. Through embodied interaction the attitudes and emotions of others are communicated. Enactments embodied through care, posture and language are also displays that communicate attitudes and emotions. Schilder (1950:247) calls these 'primary data,' information which is then perceived and interpreted, that will subsequently influence and inform the self's formation of its own body image. For Schilder, body image is always a fluid construction underpinned by continual differentiation and integration where memory, accumulated knowledge, and past and current experience informs responses and repositioning within body image in the present, and which is contingently re-assembled and projected into the future. By integrating bodily, social and emotional experience into psychic formation Schilder moves theoretically closer to earlier American sociologists like Cooley (1964, 1998) who contends the psyche is socially constructed, since it always emerges from within the context of social interaction. More will be said about the ideas of Cooley whose work is discussed below.

Schilder (1950) emphasises that the construction of body image is necessarily a social phenomena informed largely by sensory perception, mediated by emotional experience which begins with our earliest childhood experiences. However, the construction of body image is necessarily an ongoing and fluid process; one which groups of socially interacting

human beings with established social structures and attendant rules of presentation, whether overt or unwritten, are universally committed to. He reiterates in his concluding remarks:

[Body image is] not static ... it changes continually according to the life circumstances. We have considered it as a construction of a creative type. It is built up, dissolved, built up again. An important part in this continuous process of construction, reconstruction, and dissolution of the body-image, is played by the process of identification, appersonization, and projection. When the body-image has once been created according to our needs and tendencies it does not remain unchanged; it is in a continual flow, and a crystallization is immediately followed by a plastic stage from which new constructions and new efforts are possible according to the emotional situation of the individual. Moreover, there is not only the continual change in our body-image but also the continual changes in its spatial relations, emotional relations of the body-images of others and the construction of the body-images of others (Schilder 1950:241).

Schilder gives a complex reading of body image construction as a physiologically and emotionally dependant process, emerging from the most intimate of social interactions, an essentially creative and manifold process enacted within the ebbs and flows of ongoing social encounters. He challenges notions that the boundaries of the body are fixed and contained. Confronting one's own reflection impacts body image in significant ways. Mirrors, he contends, highlight how the boundary of body image is transgressed by the capacity to reproduce body image outside the parameters of the material body (Schilder 1950:278). Our fascination with mirrors underlines the lability of our own body image and attests to the incompleteness we feel towards it, which is reiterated in the ongoing labour required to construct and reconstruct the image of our body (Schilder 1950:273). His work allows us to contemplate that a phenomenon such as cosmetic surgery may be more complicated than the vanity it is commonly perceived to be. Schilder has much to contribute to psychosocial understandings of body image and intercorporeal experience, albeit without the necessary consideration of gender which would enter the critical radar of social scientists, and feminists in particular, several decades later.

Finding unity in reflection: The "Mirror Stage"

Also writing in the 1930s and vexed by questions of body image and the contentious sense of unity its visual certitude implies, Jacques Lacan (1936/77) explores the relationship between subject formation and the acquisition of body image. Like Schilder (1950) above, Lacan's theoretical credentials emerge from the discipline of psychoanalysis and, although he does not acknowledge Schilder in the development of his concept of the 'mirror stage,' he favourably cites his work on body image in later writing (Lacan 1953). Lacan traverses similar terrain to Schilder in attempting to explain the emergence of primary narcissism but his account is much more precise as to how this developmental event unfolds. In the 'mirror stage' Lacan conceptualises how the apprehending of one's own reflection in a mirror contributes to the formation of the self. In an influential paper, first presented to the International Psychoanalytical Congress in 1936, Lacan claimed that the 'mirror stage' occurred at a time between the age of six and eighteen months when the infant first begins to recognise its own reflection in a mirror. He denotes this perceptual event as a transformative event which inaugurates a sense of ontological structure, which in turn orientates the infant to the social world. Lacan highlights two outcomes of this developmental effect which are of interest here. The first relates to the emergence of the consciously embodied social self and the second to the problematic relationship between the specular image and the material body which the mirror stage precipitates.

Firstly, as Lacan (1977) argues, the human infant is born with a specific form of prematurity in that it is fully dependant in early infancy and lacks both muscular control and motor coordination. Freud has suggested that the infant, up until the mirror stage identified by Lacan, believes its identity to be continuous with that of the primary care-giver, usually the mother. Significantly, the mirror stage occurs at around the same time as weaning and the separation of the infant from its primary care-giver. How the infant resolves the inevitable separations from parental figures within the familial unit are central themes within psychoanalysis. Lacan contends that up until the mirror stage the infant does not recognise itself as a social being. Rather, it is with the apprehension of the specular self that the infant begins to orientate itself both ontologically and physically to the world in which it lives. In identifying its specular image the infant comes to recognise itself as a spatial entity, separate

from, but akin to, those individuals who surround it. Informed by these new insights, the infant begins to direct control of its limbs to imitate the physical gestures of those who inhabit its immediate environment, thus embarking upon processes of physiological socialisation and libidinal normalisation. In effect, it is the apprehension of the specular image and the recognition of the body as a separate and bounded entity that initiates primary narcissism and launches the infant as a nascent subject into the social world.

The second observation Lacan (1977) makes about the 'mirror stage' relates to the divisive impact of assuming the specular image on the formation of subjectivity. Before encountering the effects of language, and the ensuing social determinism which will come to define it, the mirror-image offers the infant a vision of an intact identity which is at odds with its own inner reality. Lacan proposed that the infant absorbs this image of its exterior physical appearance as a locus of secondary and social identification which informs the infant of who s/he is and how s/he appears to others. However, the specular image is not a reality but an illusionary mirage that is falsely suggestive of a coherent identity and sharply contrasts with the dependant and fragmentary reality of the infant body and the inner turbulence which animates it. Apprehending its reflected image in infancy introduces and establishes an ongoing and discordant relationship which it will be necessary for the evolving subject to resolve. Lacan characterises this existential tension between inner reality and outer appearance as inherently problematic.

The significance of the mirror-image lies in the framing function it offers in directing the fragmentary body and the symbolic permanence it affords the subject. However, while the symbolism of physical appearance confirms 'the mental permanence of the *I*, at the same time ... it prefigures its alienating destination,' the mirror offers an ideal representation of identity which resembles a 'statue in which man projects himself' while denying 'the phantoms that dominate him' (Lacan 1977:2, 3). For Lacan, the failure to recognise the gap between the illusionary nature of the reflected, coherent exterior and the inner tumult of the fragmented self installs a relationship between an inner truth and body image which is inherently alienating. As Anthony Elliott observes:

Lacan's human subject is thus formed in the fissure of a radical split ... In the very formation of the imagery, the human subject becomes other to itself. And it is, moreover, continually threatened by its otherness. As a mirage of unity and coherence, then, the imagery order is the basis upon which human beings construct a *misrecognized* centre of self (1992:129, original emphasis).

Themes of separation, fragmentation and the desire for unity haunt the inner world of the Lacanian subject. Concurring with Lacan (1977), the accounts of those who have cosmetic surgery articulate a desire to resolve inner discord by amending the exterior of their bodies; an exterior that has become "other" and no longer sustains an idea of the inner self. The mirror stage illustrates the reliance which the decentred self places on the reflected image in defining subjectivity. Evident in the participants' aspirations is a clearly articulated desire for a sense of wholeness where inner self and image are unified. Most believed that cosmetic surgery would not only ameliorate body image, but that improved body image would also provide the coherent unity which the fragmented inner self requires.

For Lacan (1977), the mirror is insubstantial, a mere flat, reflective surface, but his conceptualisation of the mediating role of mirrors in directing contemporary selfhood highlights the importance which modern selves attribute to the exterior of the body as a site where self-mastery is displayed. In Lacan's conceptualisation of the 'mirror stage' selfhood depends upon a negotiation between a fragile inner psyche, which requires continual stabilisation, and the exterior of the body, which inevitably changes throughout the life course and is continually open to a range of changing social meanings. While Lacan's 'mirror stage' illuminates the inner tensions between psyche and body image, which the mirror image confuses in the notional formation of the self, his formulation confines this dialectic to the bounded self, in effect excluding the social dimensions that provide the settings from within which ideas of selfhood emerge and are informed.

Cooley and the "looking glass self"

To stay with the theme of mirrors and further explore how body image is constructed as an interactive, intersubjective and social process it is useful to consider the 'looking glass self'

conceptualised by Cooley in 1902. Like Lacan (1977), Cooley (1964) was interested in how infants encounter their own images in the mirror. Cooley observed that, at around two years of age, children begin to experiment in front of the mirror with facial expressions and gestures in what he describes as a rehearsal of social performance. For Cooley, the idea of the self, and the body as the site of the self, is predicated experientially within interactive social processes. Cooley observed his own small children at play and noted their ongoing conversations, spoken aloud to an imagined interlocutor. Such observations led Cooley (1927, 1964) to suggest that our notions of self emerge out of an imagined inner dialogue with those around us. Here the psyche itself evolves, develops and is shaped in response to the social world it inhabits. Cooley writes:

Society is an interweaving and interworking of mental selves. I imagine your mind, and especially what your mind thinks about my mind, and what your mind thinks about what my mind thinks about your mind. I dress my mind before yours and expect that you will dress yours before mine. Whoever cannot or will not perform these feats is not properly in the game (1927:201,202).

As Philip Reif (1962:xv, xvi) writes in an introduction to Cooley's *Social Organization*, it is from 'this tight erotic weave of reciprocal imagining, both self and society achieve their unity.' Cooley's (1927) use of the term 'dress' is suggestive on a number of levels. To dress a wound is to approximate skin in the process of healing, where the fibres of bandage or cloth offer protection to broken skin. By covering the skin with cloth in the prosaic act of dressing, clothes become the cultural projection of skin, evidence of the way in which the body is socially reconstructed with cultural artifice (Scarry 1985:282). In Cooley's reading the mind is socially and cognitively constructed within the social context and the mind parallels the body in requiring dressing, a form of intentional, adaptive and social grooming essential to being in 'the game.' Cooley implies that 'the game' is the dynamic social world where the socially successful are players. He suggests that participating actors imaginatively and reflexively invoke an evaluative third party as an informative guide in managing and regulating both body and thought in alignment with the prevailing social expectation required to participate in the social contexts he calls 'the game.'

Like Lacan (1977), Cooley's (1964) elaboration of the experience of confronting one's image cannot be measured as a quantifiable reality; rather it involves enlisting abstract and imaginative capacities. In Cooley's (1964) concept of the 'looking glass self' the idea of the self is formulated, both metaphorically and literally, as an evaluative and imaginative assessment which occurs in symbolic interaction with one's social surroundings:

As we see our face, figure, and dress in the glass, and we are interested in them because they are ours, and pleased or otherwise with them according as they do or do not answer to what we should like them to be; so in imagination we perceive in another's mind some thought of our appearance, manners, aims, deeds, character, friends and so on, and are variously affected by it ... A self-idea of this sort seems to have three principle elements: the imagination of our appearance to the other person; the imagination of his judgement of that appearance; and some sort of self feeling such as *pride or mortification* ... the thing that moves us to *pride or shame* is not the mere mechanical reflection of ourselves, but an imputed sentiment, the imagined effect of this reflection upon another's mind (Cooley 1964:184 emphasis added)

While it is clear that Cooley (1964) is not referring solely to appearance, it remains equally certain that appearance is central to the construction of 'self-idea.' Firstly, the self, in confronting the mirrored image reflexively, imagines the reactions of an audience to whom the performance of appearance is directed. For Cooley the very idea of the self and its embodied appearance can only be defined and created within the framework which available social structures provide. Secondly, the process of socialisation established in early childhood, as Cooley describes it, continues to operate throughout adult life. Moreover, imaginatively invoking the appraisal of others in turn confirms and reinforces a judicial and regulatory function around appearance norms and standards which social participants are expected to meet. As Cooley (1964:203) suggests, 'Directly or indirectly the imagination of how we appear to others is a controlling force in all normal minds.' A third element of this reflective process highlights the emotional investment embedded within such an appraisal. Pride and shame are offered as the emotional extremes which self-monitoring might evoke, and the feelings instated through this appraisal are then refracted through the imagined thoughts of others. Whereas 'pride' implies satisfaction with appearances and, accordingly, social approval; 'shame' has connotations of humiliation and potential rejection. A failed

performance suggests punitive consequences, exclusion and marginalisation: being sidelined in 'the game.' Clearly, a position at the borderlands of the social is an undesirable and uncomfortable place, although Cooley does not expand on what this might entail. Cooley's 'looking glass self' makes tangible the interactive matrix and resultant constraints from which the idea of the self emerges, while also alluding to the inherent vulnerabilities embedded within bodily expression. However, while the emotional consequences of failing to meet the standard of one's social group are introduced by Cooley, he does not develop them further.

Confronting body image

Viewing their body critically before a mirror figured strongly in the accounts of those who participated in this study as an important procedural precursor to undertaking cosmetic surgery. As Cooley (1964) implies, and Lacan (1977) suggests, critiquing oneself in a mirror has the significant effect of repositioning the reflected image as 'other' to the self. In day-to-day life, appraising one's appearance may be a fleeting act, a quick affirmation prior to leaving the house, or a lengthier but nonetheless routine preparation which, more often than not, involves some form of ritualised grooming and marks the conscious transition from the private to the public realm. To invoke Goffman's (1974) theatrical metaphor, assessing the self in the mirror is a transgressive but private, backstage affair where one's preparedness for encountering the front stage of the social world is rehearsed. Goffman distinguishes between front and back stages but these grooming rituals occur spatially in the backstage realm where the self is psychologically and imaginatively, visualising itself in a front stage social domain. Such space is neither front nor backstage but an interstice on the cusp between the two: a rehearsal zone, a place where one practices, anticipates and re-hears one's social performance. It was in this in-between space, before the mirror that the evaluation of body image and the rehearsal of surgical transformation took place, culminating the sequence of events which lead participants in this study to contemplate and undertake cosmetic surgery. The experience of one participant illustrates how such a process might unfold. Tanya had four children less than five years of age by the time she was twenty-eight. Her third pregnancy had resulted in twins which brought about marked changes in her body. She had been at

home, absorbed with her children, breastfeeding and unconcerned about how her body looked, but she was able to pinpoint the moment when that changed:

Jane: So was it coming out of the pregnancy that you had issues with your body?

Tanya: Yep, (said quickly) soon after I'd had the girls. I really wanted to breastfeed them and did everything I could and luckily for me I had lots and lots of milk ... They were feeding every three hours so I was always quite large. And ... I'd eat whatever I wanted to eat so that I could have this milk supply ... But as the girls got a little bit older I started to get really conscious about the way I looked. So probably when they were about, oh, ten months old, basically when I went back to work, I just took a really good look in the mirror one day and thought, "Oh, I don't like this any more." So I went to the gym for twelve months and just slogged it out there trying to lose weight. And I joined Weight Watchers. I was doing all the right things, eating well and exercising and I lost heaps of weight, but the thing that was still left were these breasts that were sitting on, you know, my stomach and ah, there was no shape to them, they were just skin. And my stomach, where the stretched skin was, was just like a, well, like an apron. It was terrible and there was nothing ... I could do about it ... *I absolutely hated it* (emphatic) ... And I couldn't, I couldn't have lived like that. To think about living like I looked, now, there is no way. I was still in my twenties; to look like that and be in your twenties was terrible.

Initially Tanya took pleasure in the maternal plenitude her *post partum* body afforded and was diligent in her efforts to sustain lactation. She was unperturbed by the changes occurring within her body. It was only as she prepared to shift the role and location of her labour that Tanya decided that what had been acceptable in the backstage of her home was not going to be acceptable in the front stage (Goffman 1974) or public world of work. As she prepared to make the spatial transition from home to work her attitude towards her body image underwent a marked change. She moved from embracing her body's maternal function to assessing the aesthetics of her appearance and loathing her perceived flaws. This was a radical shift. Reviewing her body image in the mirror and evaluating it within the wider standard of what is considered an acceptable female appearance, Tanya moved from pride to shame (Cooley 1964).

In her essay on abjection, which informed and orientated the conceptualisation of shame developed in this study, Julia Kristeva (1982) claims that the maternal body is always abject, discarded in preference for the clean and proper masculine world of power. Moreover, it is a woman's generative potential that relegates her to the animal realm; her perforate body with its leaky margins threatens defilement and impurity. Hers is a dark and dangerous power, both loathed and feared; against which anthropologists observe pollution ritual has been instigated as means of protection (Kristeva 1982, Douglas 1966). In Tanya's account, body loathing only emerged in her self-conceptualisation when she re-evaluated herself through the eyes of another who would, in turn, evaluate her as a prospective employee in the competitive domain of the labour market. If we agree with Kristeva, the maternal loathing underpinning and sustaining patriarchy is replicated and reinforced when individuals introject maternal loathing as self-loathing. Feminist authors such as Wolf (1991) nominate body loathing as a normative feature in the self-image many women have of themselves. Moreover, as Wolf asserts, the consequences of self-loathing are absorbing, debilitating and undermine the capacity of women to enact and realise their full potential.

Tanya's use of the mirror as an evaluative tool in reassessing her body image is significant. When the self is 'mortified' or 'shamed' by the appearance of the body reflected back, as Tanya was, and as was frequently expressed by other participants in this study, self and body image fragment in disembodied disunity. Standing before a mirror enables the viewing self to distance itself imaginatively from its own bodily image in a conscious move which severs the self from the reflected image and rejects that image as 'other,' in a move which is similar to the disembodied experience of the body in pain invoked by Schilder (1950) earlier. This rift is significant and realigns thinking with the approach taken modern medicine. The rejected body is subsequently rewritten and reviewed as a site of pain: not physiological pain, but the psychosocial pain of exclusion. Tanya could not imagine that she could have continued to live looking like she did because it would have meant suffering an intolerable existence. Davis (1995) observed similar narrative themes in those she studied who had had cosmetic surgery. She writes that regardless of whether suffering was a longstanding or recent characteristic of the relationship between self and body, 'Cosmetic surgery was presented as the final step in a trajectory of suffering – an attempt to alleviate a problem

which had become unbearable' (Davis 1995:74). By re-presenting the body as a site of suffering and the psyche as wounded, the body/self is reframed, medicalised and can justifiably seek the particular healing of body and soul which cosmetic surgery implies it is able to deliver.

Tanya's story is also interwoven with the moral concepts of sacrifice and entitlement which draw heavily on the classic Judeo-Christian model. She had been a 'good' mother, selflessly surrendering her body so that her offspring may thrive. Her body's response to multiple pregnancies was entirely within the normal spectrum, but for her it was unendurable and, she argued, something beyond her control. She had 'done all the right things' and 'slogged it out' at the gym to improve her body image herself. When her sustained efforts failed she began to consider cosmetic surgery. Tanya understood that arguments around having cosmetic surgery are contentious and elsewhere reasoned that because her bodily changes occurred as the result of pregnancy, and not through some less credible cause, it was easier to justify having cosmetic surgery. This rationale allowed her to neutralise any guilt she may have otherwise felt. Accounting for cosmetic surgery by elevating one's moral character was a defensive strategy observed in a number of interviews and has been noted by other researchers (see Gimlin 2000 for example). However, the employment of defensive narrative themes, while not insignificant, should not be overemphasised since the contextual nature of the interview may inadvertently contribute to their formation and inflate their importance. I will return to this point in a later chapter.

While the mirror serves as an evaluative tool in establishing and managing body image, it also allows the viewing self to fantasise and actively reconstruct an alternative body image. In rehearsal, the self reinforces the inherent plasticity of its flesh by literally pinching, pulling and pushing at its margins, to simulate the metamorphosis of its material surface. Alone before the mirror, imagining the changes which cosmetic surgery might initiate, the viewing self is able to re-construct a preferred image. In the months before proceeding with cosmetic surgery one participant spoke of using two opposing mirrors in her bathroom to view her face in profile. By repeatedly running her finger along her nose she began to envisage how she might look if her nose were to be reduced by rhinoplasty:

I have a side mirror in my bathroom, I would stand there and hold my finger on the other side of my nose and then blur my vision so that I could see what it would look like if it was straight. And I'd do that so many times, I just did that over and over again, because that's what I wanted, a straight nose (Ava).

Through imagination a mirror enables the viewing self to make tangible another, preferred version of its own image. Ava's pre-surgical rehearsal illustrates how she progressively internalised the transformations she sought to make corporeal through cosmetic surgery. Like others in this study, critiquing and re-imaging an alternative body image before the mirror enabled her to practise and incorporate her surgical transformation long before the cosmetic surgeons' services were enlisted, or 'commissioned' as one participant pointedly described it.

Other participants spoke of confronting their facial or body images reflected in other media forms such as photographs or home movies. Such instances were nominated as pivotal in affirming the unacceptability of appearances and determining that surgical intervention was the only option left. Along with the mirrored image, such evidence was added to the catalogue of rationales which participants gave as their reasons for undertaking cosmetic surgery. Margaret, for example, had always disliked the appearance of her face and neck. She assiduously avoided being photographed and had developed strategies to disguise her most despised features in the event that it became unavoidable. However, being filmed at a family wedding, without being given the opportunity to initiate any such strategy was the catalyst that saw her proceed with cosmetic surgery. Margaret was in her early sixties when she had a face and neck-lift:

Margaret: I had cosmetic surgery because I looked a bit like the "Hushpuppy" dog. Everyone *always* thought I looked tired ... And I got sick and tired of people telling me that I looked tired all the time. I really did. I had big, *big* bags under the eyes ... I just didn't like, I didn't like the way I looked. But the thing that really got me was when I saw the DVD of my niece's wedding a few years ago. At one point in the ceremony the camera was on me and I had this *great thing* here (pointing to her neck). And I thought it really *is* awful. I would never have my photo taken, *ever*. And any photos that I do have (she reaches to show me some photos lying on a nearby

bench) well, you can see there. Now, that was taken a few weeks before the wedding, that area was always very red and I was always conscious of this big band around here (she points to her neck in the photo). In any photos, I always have my hands on my chin (so her arms obscured her neck). I couldn't, *I couldn't bear it*. I'd been thinking about it for some time, so I decided to go ahead with surgery.

Jane: So what you are describing sounds like a really strong feeling of revulsion?

Margaret: Yes, it really was. People have said to me, "Oh I didn't notice it." *How can you not notice a thing that has red capillaries all over it* (said with just a hint of anger and an air of incredulity) (original emphasis)?

Margaret's abhorrence of her pre-surgical neck and facial appearance is unmistakable, but another observation needs to be made. For Margaret, having cosmetic surgery also availed the opportunity to reclaim her own body image. Her account highlights the very public nature of the body. It is presented, on display and therefore subject to the critique of others. Margaret's body conveyed impressions which were at odds with how she felt and it is the oft repeated comments about tiredness that she hoped to silence. The tension created by a body image that fails to convey the feelings of the inner self is a central conflict which cosmetic surgery seeks to resolve (Davis 1995 and Gimlin 2006 have made similar observations). However, it was the unambiguous dislike of her body image so clearly stated by Margaret, a dislike which was relentlessly repeated across the interviews that both surprised and challenged me. Body image loathing was articulated as a pre-surgical rationale for engaging in cosmetic surgery across all interviews. It constituted an oppressive and persistent feature of embodiment for those with complex body image issues, and was presented as a transient characteristic for those for whom body image dissatisfaction was a more recently experienced phenomenon. Explaining this dissatisfaction became a central aim of this study. From the earliest analysis of participant accounts I was directed back to theorists in an attempt to find the tools with which an emerging discussion of body image dissatisfaction might be framed. Along with mirrors and the inevitable function of evaluation they appeared to engender, shame emerged as a conceptually significant potentiality when body image is evaluated as unsatisfactory. Through the concept of shame introduced in this chapter I will attempt to further explore the problematic relationship between the women who took part in this study and their troubled body images.

As has been discussed through the work of Schilder (1950), Lacan (1977) and Cooley (1927, 1964), body image is a fluid and fragile process through which we orientate ourselves as social subjects within the wider milieu of the social world. Integral to the process of evaluating, constructing and reconstructing body image is the mediating and divisive potential invoked by mirrors. Mirrors are modernity's evaluative tools par excellence, bestowed upon our backstage realms and rehearsal zones by courtesy of technological progress and demographic change. Inadvertently, these shifts have provided an unprecedented capacity for both the scrutiny and destabilisation of body image. I am not suggesting that mirrors are intrinsically problematic; rather, there are consequences in their proliferation, particularly in the way we have come to view body image. Mirrors potentially encourage the vulnerable self to fracture into body image and mind by repositioning the reflected body image as an object which is subject to the detached and appraising mind. With the increasing awareness and progressive normalisation of cosmetic surgery, the gaze of the cosmetic surgeon is introjected and incorporated into the gaze of the critical viewer. The surgeon's preferred aesthetic standard reflects, wider culturally venerated forms of womanhood which deny the ethnic (Kaw 1993) or ageing face, variation in breast size and shape, and the physiological change common in the *postgravid* woman, thus reducing and narrowing, in subtle and complex ways, the physiological potentiality of female embodiment. Cosmetic surgery not only limits the possibilities of female appearance by homogenising physiological difference, it actively promotes a sexualised view of women which reinforces the notion that young women of reproductive age are the feminine ideal. Cosmetic surgery's preferred designs for women shift women towards an ideal akin to that of masculine sexual desire. The new category of 'hot mama' or 'yummy-mummy' trail-blazed by celebrity mothers who, with the help of cosmetic surgeons, speedily rebound from pregnancy, is promoted as normal, desirable and achievable within a matrix of consumptive choices framed around grooming. Moreover, these terms are cute, unthreatening and intended to be appealing. I have had young childless women perkily tell me that they would *definitely* have a 'mommy makeover' after they have their children, and I have been urged to look to Britney Spears' post-caesarean body should I require any more proof of the benefits. In much of the popular discourse promulgated around cosmetic surgery there are discursive trends which normalise surgical procedure and deflect from its seriousness.

The inevitable rise and increasing normalisation of cosmetic surgery can only exaggerate and exacerbate the feelings expressed by the majority of women who took part in this study; that self-image and body image are necessarily intertwined and tied to wider constructs of body image. As is evidenced in the accounts above, participants typically revealed varying degrees of shame and rejection of their own body image. After exhausting other avenues such as weight loss, exercise and make up, cosmetic surgery was embraced as the only measure available to ameliorate self-image. For the woman who looks in the mirror and does not like the image of her own body reflected back, cosmetic surgery offers a tangible solution to the problem. Underpinning all cosmetic surgery is the desire for a more unified self, to look in the mirror and like what one sees rather than being dismayed by it. However, I found myself increasingly questioning whether cosmetic surgery as a medical intervention is able to resolve unhappiness with body image, as is generally claimed, or does it do the exact opposite and magnify unhappiness with appearance? I will return to this question in future chapters.

In this chapter I have explored the themes of mirrors and body image which emerged from the interviews recorded for this study through some of the most plausible theories I encountered while reading for this project. In the work of Cooley (1964) we find the suggestion that the construction of a self-image involves ongoing evaluative processes which denote social worthiness within an axis that traverses the extremes of shame and pride. I have proposed that body image, as a component of self-construction, is evaluated along similar lines. Cooley suggests that shame and pride are implicated in self-experience but does not expand upon his discussion in any detail. Shame, as I was to find, and as its meaning suggests, is hidden. Shame appears to be a feature of everyday experience but paradoxically, 'like an elephant in the room,' has only been subjected to limited academic scrutiny. Making a link between an abhorred body image, so resoundingly voiced in descriptions of pre-surgical appearance, and the possibility that shame might be implicated became an important focus of this study. The following chapters will consider sociological and psychoanalytical contributions to the conceptualisation of shame and how insights acquired from these sources might advance understanding the relationship between poor

body image and the initiation of cosmetic surgery. In the next chapter I consider shame, beginning with the formulation proposed by the sociologist Norbert Elias (1978).

Chapter Four: Shame and the Social Self

The first book of the three volumes comprising *The Civilizing Process*, written by Norbert Elias (1978), gives a leading role to the internalisation of shame as a central determinant of modern social life. Drawing on literary texts and etiquette manuals inherited from feudal times through to court society, Elias argues that the 'civilizing process' is, at its most basic level, the existential process of becoming increasingly self-conscious about personal behaviour and bodily function that has evolved and emerged in Europe over a period of many centuries. A central characteristic of the civilising process is the relationship between the ruling classes, and the social rules they progressively formulated around bodily function, and the psychical process which emerged as the broader population felt increasingly compelled to uphold and sustain such rules. A significant outcome of the civilising process has been an increase in anxiety experienced at the level of the individual, symptomatic of an internalisation of shame, which can be directly correlated to the fear of being socially excluded should the culturally agreed sanctions surrounding bodily comportment be breached. Rules surrounding bodily comportment are not fixed but are constantly modified and attuned to shifts in cultural preference. Elias' (1978:xiii) writes: 'The standard of what society demands and prohibits changes; in conjunction with this, the threshold of socially instilled displeasure and fear moves; and the question of sociogenic fears thus emerges as one of the central problems of the civilizing process.' Elias nominates fear and anxiety as emotionally and socially implicated in the individualised management of shame, embodied interaction and wider social structure. Moreover, anxieties around the body have evolved in response to rules around bodily comportment becoming increasingly defined. Members of the aristocratic classes were the first arbiters of manners and corporeal management. With their demise, Elias, in agreement with Freud, nominates intergenerational socialisation and its locus, the family, as the primary site where notional ideas about what is acceptable or otherwise regarding subjective bodily management are learned, embodied, regulated and reproduced. In this chapter the ideas which Elias proposes are explored. In the second part of this chapter I return to participant accounts to examine how these ideas can be utilised to develop an understanding of the way in which shame is implicated in the experiences of those who undertake cosmetic surgery. In exploring emergent themes from the participant

interviews distinct correlations are noted with those presented by the anthropologist Mary Douglas (1966). Her work is introduced in an attempt to develop a more complex understanding of the relationship between shame, gender and cosmetic surgery.

Firstly we begin with Elias' (1978) formulation of the 'civilizing process' and how shame has emerged as a significant feature of that process. History and demographic movement are centrally important to Elias' theoretical formulation. Fundamental to the civilising process, which he proposes, has been the spatial distancing of humans from nature incurred in the demographic transition from pastoral to urban living. A consequence of that shift has been an overarching project to distance humans from their pasts or, more literally, their pastoral origins, when human and animal coexistence occurred in much closer juxtaposition. Elias claims that 'people, in the course of the civilizing process seek to suppress in themselves every characteristic that they feel to be "animal"' (1978:120). This has occurred gradually over many centuries by the sequestering of socially undesirable, instinctive or impulsive behaviour to the privatised backstage of social life. Etiquette manuals examined by Elias demonstrate how aversion became attached to those behaviours evaluated to be ill-mannered. Indeed, from the earliest poem on table manners, written in the thirteenth century, an ordering of behaviours is evident: 'Those who stand up and snort disgustingly over dishes like swine belong with other farmyard beasts;' snorting like a salmon and gobbling like a badger is deemed improper; to slurp from a spoon is 'bestial' and drinking while eating is something only animals do (cited in Elias 1978:85, 86). Similar themes are repeated in etiquette manuals centuries later and are, of course, recognisable today as the familiar reprimands applied to those who breach table manners, usually children. Nose blowing, flatulence, where and when not to spit, how to behave when sharing an inn room with a stranger and how to respond when encountering someone defecating in public are some of the topics which receive the attention of the etiquette authors whom Elias consults. Over time, as people's living arrangements shifted from agrarian to urban settings, an increasing emphasis was placed on the spatial contexts of interpersonal relationships and how individuals managed and controlled the parameters of their bodies.

Elias (1978) explains the adoption of the manners and affectations of the court by the lower-classes as an aspirational trend which had its genesis in the demise of the aristocracy. A knowledge and utilisation of manners was gradually appropriated by the middle-classes in the eighteenth century as the power of the aristocracy weakened and interaction with an emergent and increasingly wealthy bourgeoisie occurred. Up until then manners, in the form of grammar, table etiquette and physical comportment, were learned symbolic representations of class which encapsulated and preserved the hierarchical position of the ruling elite (Elias 1978:101). The diminishing paternalism of the court also brought a shift in the responsibility for socialising the children of the aristocracy. This had been the domain of the court but, with its dismantling, the role shifted increasingly to parents.

Of considerable significance to Elias' (1978) argument is a short volume, *On Civility in Children*, written by Erasmus of Rotterdam around 1530. Reprinted up to one hundred and thirty times, the most recent in the eighteenth century, and translated into English, German, French and Czech, this book was considered an influential manual for the sons of the aristocracy. As with earlier manuals there is advice on table manners, washing one's hands before eating, wiping one's mouth before drinking, wiping the rim of a goblet before passing it on and not dipping bread that has already been bitten into the serving platter. It is, perhaps, important to recall that eating was a communal act which, particularly prior to extensive cutlery and crockery manufacture in the sixteenth century, involved sharing from a communal dish and drinking from a goblet that was also shared. Rules around eating demanded consideration for those with whom one dined, and explicit regulation of the transmission of body fluids was stipulated long before the discoveries of bacteriology became the motivation to modify such behaviours. Erasmus draws a distinction between those who can control their behaviour at the table and those who cannot. Savagely derided as the behaviour of the inelegant or the insane; scratching, spitting and snorting 'comes from a rustic embarrassment and looks like a form of madness' (Erasmus in Elias 1978:57, 56). Lack of control and insanity are interconnected in lay interpretations today and continue to carry the same connotations. From the table to the bedchamber, Erasmus writes with a frankness that may well be embarrassing to contemporary societies, further underscoring the

way in which the more 'primitive' aspects of corporeality have become selectively private topics of conversation.

In his examination of influential etiquette texts, Elias (1978) uncovers repeated themes which prompt him to argue that judicial evaluations surrounding the most permeable regions of the body's margins have resulted in an evolving repugnance at uncontrolled bodily function which has, over many centuries, increased self-consciousness surrounding the body. This self-consciousness has subsequently been internalised at the level of the individual, manifesting in an advancing of the threshold of shame directed towards the body. In turn, the body has evolved symbolically as a significant site upon which self-control is measured and displayed. Concomitantly, at a wider societal level, discussions of bodily function have increasingly become prohibited and consequently repressed. Indeed, what Elias attempts to illustrate is

how the constraints of others from a variety of angles are converted into self-constraints, how the more animalic human activities are progressively thrust behind the scenes of men's communal social life and invested with feelings of shame, how the regulation of the whole instinctual and affective life by steady self-control becomes more stable (1982:230).

The relationship between the constraints of others and subsequent self-constraint in identity construction and self-evaluation is also of central importance to psychoanalytical discussions of shame and will be discussed in the next chapter.

Divided selves: inside/outside

Within the writing of Erasmus, Elias (1978:78) detects a distinct shift to an observational mode which he suggests had implications for the way in which people integrate, assess, assimilate and participate in social life. This shift was part of a more general paradigmatic trend within scientific and cognitive processes towards the reductive and classificatory systems characteristic of Enlightenment thought. Elias suggests that this shift to an observational mode, where the emphasis of social control moves to observable behaviour and, with it, increased anxiety experienced by the individual, was the origin of what would later

become 'psychological' (1978:78). Foucault (1977) has covered similar terrain in his conceptualisation of 'surveillance.' Appearing for the first time in the etiquette manuals examined by Elias is a focus on presentation. 'Clothing' writes Erasmus (cited in Elias 1978:78), 'is in a sense the body of the body. From it we can deduce the attitude of the soul.' Outward appearance in the form of grooming, gesture, clothing and facial expression came increasingly to be read and understood as representative of the inner person, the essential self. Careful observation of those with whom the social world is shared and the interpretation of visual representation as a way of understanding inner motivation became obligatory, and indeed integral, to the notion of *civilité*. Whereas bodily function and manners had previously been the focus of social rules, which urged and instilled self-consciousness and self-restraint, bodily appearance was now added to the expanding parameters of self-consciousness and progressively became a primary site of angst and potential shame.

In his introduction to the 1968 edition of *The Civilizing Process*, Elias (appendix 1978) critiques the role which dualisms have played in creating an intuitive but illusionary image of 'man.' The oft repeated comment "I look older than I feel" plainly illustrates what is today accepted as a self-evident assumption that the self is composed of an inner essentialised self, here out of sync with an outer image. A closer examination of participant accounts reveals how feelings of separation and fragmentation divide the self from society, the inner self from body image, and are mobilised as rationales by those who undertake cosmetic surgery. They are also found in medical discourses which promote and normalise cosmetic surgery. A capacity to fragment and differentiate the self appeared to be intrinsic to the process which culminated in cosmetic surgery.

Dualistic thought has deep roots in the European intellectual tradition inherited from the seminal writings of Greek philosophers, Christian clerics and the Cartesian *cogito*. Evident within the foundational doctrine of Platonic thought is a profound disdain for the body. Here the spiritual dimension of the mind, soul or reason is characterised as captive and betrayed by the fleshed prison of the body. For Plato it went uncontested that the body required ruling by the reasoning mind. He extends this metaphor to encompass a self-evident model of hierarchy which he perceives as a natural relationship between the ruler and that which

requires ruling in order to sustain harmony at the level of the state, family and the self (Grosz 1994:5). In Christian thought dualisms were reconfigured to represent that which is moral and immoral, interpreted through manifestations inscribed upon and from within the body. Grosz's (1994:6) reading of Cartesian dualism argues Descartes went further than separating mind from body to separate the soul from nature. Descartes defines the body as a self-moving mechanical force causally driven by the forces of nature and the soul as separated and excluded from the world of nature. Grosz (1994:6) writes, 'This exclusion of the soul from nature, this evacuation of consciousness from the world, is the prerequisite for founding a knowledge, or better, a science, of the governing principles of nature, a science which excludes and is indifferent to considerations of the subject.' What Descartes accomplishes is a belief in the certainty that reality can only be confirmed indirectly by the deductive powers of scientific confirmation. He succeeds in linking mind/body to 'The foundations of knowledge itself, a link which places the mind in a position of hierarchical superiority over and above nature, including the nature of the body itself' (Grosz 1994:6). From the time of Descartes, consciousness has been elevated above corporeality, and the problem of this legacy continues to occupy and gridlock contemporary philosophical debate. Yet to be explained is the way in which two extreme, oppositional and apparently irreducible spheres, in whatever juxtaposition, interact.

Of particular interest to Elias (1978) is the divisive effect which dualisms have in separating the self from society, and how that severance in turn impacts upon self-perception and social structure. The move from an agrarian lifestyle to high density urban living, and the challenge to traditional systems by rationalist scientific doctrine, have initiated other transitions at the level of individual experience in the form of affect control and inner restraint. In turn, these changes have transformed human relationships with the natural environment, where nature has similarly become subject to control, particularly as a resource within capitalist economies. The scientific refutation of previously held beliefs, which proclaimed that everything which occurred in the natural realm was related to human destiny, resulted in a detachment from nature where objective knowledge, guided by scientific thought, gives meaning and purpose to nature only when it is subject to control (Elias 1978:256). Separated from the self, the fleshed body, like nature, came to have meaning only when it is subject to control.

Furthermore, anatomical imagery which depicted the outer body as the encasement or container of vital bodily organs, the brain and heart in particular, confirmed the notion of 'invisible walls' encapsulating and separating the 'inner self,' or subject of cognition, from 'other' objects such as the body, or society. Embedded within these cognitive shifts is the legacy of Western epistemology which, Elias contends, confuses abstract separation with actual separation:

Herein lies one of the keys to the question of why the problem of scientific knowledge took on the form of classical European epistemology familiar today. The detachment of the thinking subject from his objects in the act of cognitive thought, and the affective restraint that is demanded, did not appear to those thinking about it at this stage as an act of distancing but as a distance actually present, as an eternal condition of spatial separation between mental apparatus apparently locked "inside" man, an "understanding" or "reason," and the objects outside and divided from it by an invisible wall (Elias 1978:256).

Elias (1978) argues that the model of human experience as closed and contained by binary systems, explicit within dualism's projection, is, in effect, antithetical to the very notion of society. Dualisms position individuals as independent and isolated entities detached from wider social forms, thus providing fertile ground for alienating emotions like shame to proliferate. Embedded within dualistic thought are primitive but highly inflexible frames which mark and uphold the epistemological categories of inner/outer, self/other, subject/object, inclusion/exclusion. Elias contends that the salience of dualistic thought at the level of the body relies upon an artificially created notion of self-perception that 'rests partly on a confusion of ideals and facts, and partly on a reification of individual self-control mechanisms - of the severance of individual affective impulses from motor apparatus, from the direct control of bodily movements and actions' (Elias 1978:260). This last point is important, as Elias appears to be suggesting self-control at the level of the body is learnt and internalised so effectively that bodily response to emotional impulses are automatically and subconsciously monitored, and that responses are simultaneously and instinctively enacted to bring restitution to social settings which shame threatens to destabilise. An example here might be the uncontrollable and observable response of blushing which is witnessed when

social convention has been breached; a topic Goffman (1967) expands upon in his essay *Interaction Ritual*.

Elias (1978) leaves open the question of how far emotional experiences of isolation and alienation emerging from poor self-evaluation can be ascribed to the internalisation and embodying of self-control; or, indeed, assessing how attributable these processes are to the structural characteristics of modern society. He is, however, more certain on how the 'image of man' emerges: not through the closed systems promulgated in dualistic thought but rather, he proposes, through interdependencies or networks of individuals who are linked by the 'figurations' or collectively created systems intrinsic to all social relationships. Figurations are not static or fixed, rather, they ebb, flow and morph in conjunction with changes in human personality structure. Figurations emerge from ongoing social processes more accurately representative of the interdependence characteristic of social life. People, Elias writes, are

fundamentally oriented toward and dependent on other people throughout ... life. The network of interdependencies among human beings is what binds them together. Such interdependencies are the nexus of what is here called the figuration, a structure of mutually oriented and dependent people. Since people are more or less dependent on each other first by nature and then through social learning, through education, socialization, and socially generated reciprocal needs, they exist, one might venture to say, only as pluralities, only in figurations (i.e., groups of societies of different kinds) with each other (1978:261).

Elias proposes that it is not productive to think of individuals in isolation when everything about an individual is learned or acquired in some form of social interaction. Echoing Cooley (1964), Elias posits that identity or notions of selfhood emerge from within the interweaving of the social experience available to the individual. Figurations themselves are not informed anew with each generation but are reproduced through the networks, or figurations, characteristic of social life. Accordingly, knowledge and meaning are evaluated, developed, transformed and transferred in ongoing processes of interaction. These insights are useful because they allow the shifting of questions about something which tends to be individualised, such as the shame associated with body loathing, to a broader social dynamic.

Women and shame

Elias (1978) only fleetingly explores the way in which women have experienced an increasing self-consciousness towards their bodies and, when he does, it tends to support his argument of a general advancement of the threshold of shame and the resulting internalisation of restraint these processes have engendered more generally in men. However, what he does have to say with regard to female embodiment is significant, particularly in the way the experiences he discusses resonate with the contemporary experiences presented in this study. In the next section I will examine selected participant accounts to illustrate how shame might be identified as a significant factor in the way participants have come to formulate their own ideas about their bodies and body image. In line with the ideas developed by Schilder (1950) which propose that body image is a multifaceted production in which the values and judgements of others are integral, and in agreement with Cooley's (1964) suggestion that the formulation of self/body image is subject to evaluation, the next section considers Elias' proposal that shame, is at its core, related to an inherent anxiety associated with an apparent failure to manage the body, and the fear of rejection which any such failure might involve. Elias has much to offer a sociological understanding of embodiment, particularly in his conceptualisation of shame, self-control and the subsequent implication of shame in the problematic relationship between body image, self and society; but his insights are consistent with his generation and only partially useful when it comes to the complex relationship which women have with their bodies and body image. Furthermore, it is the physiological link to nature that has long cast women as inferior to men; a link which feminists have steadfastly argued elevates and sustains patriarchy as the dominant paradigm. The structural relationship between female corporeality and the perpetuation of patriarchy, particularly within the framework of dualistic thought, has been challenged by feminist writers but their focus has tended to privilege social and power inequities. The pervasiveness of shame and the way its dynamic is played out in private and public arenas has attracted the interest of some feminist scholars (see for example Bartky 1990, Skeggs 1997, Probyn 2005), but the role of shame in informing and shaping the embodied lives of women is yet to be fully explored.

Sex, socialisation and shame

Elias (1978) examines one etiquette manual specifically written for the parents of girls by Von Raumer (1857) titled *The Education of Girls*. It is worth repeating some of what Elias (1978) cites from this manual as it reveals much about how mothers were encouraged to inform their daughters about reproduction in the nineteenth century. The following quote also illustrates how pedagogy was reproduced in the figurative relationship between the church and family, interweaving and converging to imbue and reinforce female embodiment with notions of shame. It begins by telling parents how they should introduce the subject of female reproduction to their children:

These things should not be touched upon at all in the presence of children, least of all in a secretive way which is liable to arouse curiosity. Children should be left for as long as at all possible in the belief that an angel brings the mother her little children ... Children if they really grow up under their mother's eyes, will seldom ask forward questions on this point ... not even if the mother is prevented by a childbirth from having them around her ... If girls should later ask how little children really come into the world, they should be told that the good Lord gives her mother her child, who has a guardian angel in heaven who certainly played an invisible part in bringing us this great joy. "You do not need to know nor could you understand how God gives children." Girls must be satisfied with such answers in a hundred cases, and it is the mother's task to occupy her daughters' thoughts so incessantly with the good and the beautiful that they are left no time to brood on such matters ... A mother ... ought only once to say seriously: "It would not be good for you to know such a thing, and you should take care not to listen to anything said about it." A truly well-brought-up girl will from then on feel shame at hearing things of this kind spoken of (Von Raumer cited in Elias 1978:180).

We see in this passage that mothers were entrusted with the responsibility of preserving the ignorance of their daughters from the truth of their biology. This extract highlights a tension between 'the good and the beautiful' and the shameful reality of female reproduction. Elias (1978) rightly struggles to understand why mothers and daughters are beholden to uphold this fantasy. There is so much left unexplained; the irrationality of the explanation given by mothers; when would young women be told the truth about their bodies? The only explanation appears to be the advancing threshold of shame, embarrassment and the

repugnance female reproduction evokes. Mother and daughter appear to be locked in a loop of deception; if a daughter fails to uphold an impression of purity then both have failed, both have fallen below the standards of what is deemed acceptable. The mothers who Von Raumer (in Elias 1978:180) is addressing are duty bound, the social emissaries of a wider belief system that upholds and replicates attitudes of shame, embarrassment and disgust toward the female body and its reproductive function which, in an absurd irony, is no less than foundational to all humanity. Moreover, the language necessary to speak of sexuality is lost and all that remains are 'dirty words' (Elias 1978:182). Invoking Elias' metaphor of the 'invisible wall' reveals how a conspiracy of silence originating from a broader figuration informed by religious doctrine and imposed upon young women via the fabrications told to them by their mothers might, in effect, separate and detach them from the biological truth of their own bodies. Through a general disgust of embodied feminine sexuality and an implicit denial of its pleasures we see repression enacted upon the female body through the modality of shame.

This may all seem so very long ago and not at all relevant to a contemporary discussion of cosmetic surgery, yet in one of the interviews recorded for this study a woman recalled the conversation she had with her own mother as she entered puberty. The attitudinal similarities observed in her experience and those recounted by Elias (1978) are striking. Rose was 50 years old at the time she was interviewed and the conversation she recalled occurred in the early 1970s seventies. Her account demonstrates how attitudes of shame directed toward the female body have persisted, 150 years on from the publication of Von Raumer's (1857) manual. In line with Elias' (1978:182) observations regarding the discursive censorship surrounding feminine sexuality, Rose assumed that her changing body and its reproductive potential are dirty and disgusting.

Rose: When my mother told me the facts of life, she brought me this little book that all the girls I knew had brought for them. But my mother sticky-taped the pages about reproduction together. So I was allowed to know about periods but I wasn't allowed to know about reproduction. When I finally found out about reproduction from a friend as we were walking home from primary school, *I was absolutely disgusted*. And I went home and told mum that she was filthy, and I can't remember what her reaction was ... But yes, mum sticky-taped those pages together

and I knew there was something I wasn't allowed to see, which made it dirty. So I think a lot of my problems come from the way I was brought up. But I also know my parents brought me up the only way they knew how, they didn't deliberately do this damage.

For Rose it was her mother's intentional act to exclude information relevant to her own changing body that tainted her feelings towards her body, and it is hard to imagine that the daughters of Von Raumer's (1857) readership felt in any way differently when the truths of their own bodies became known to them. As an intelligent and reflexive adult, Rose understood that her mother's actions were well intended, informed by a limited set of available belief systems and in keeping with the conventional wisdom of the time. However, Rose also recalled the impact of the inference that excluding relevant information about her changing body had upon her. It made the sexual act 'dirty,' and, by association, it made her changing body 'dirty.' Like the mothers whom Von Raumer addressed a century earlier, Rose's mother may have believed that she could preserve her daughter's purity or prolong her childhood by withholding information pertaining to sex. Whatever her mother's motivation, it became clear as Rose continued through her interview that her relationship to her body was, and continued to be, deeply complex. Moreover, it became increasingly evident that the attitude of her parents towards her changing body had cast a long and persistent shadow of shame over her relationship to her body and body image.

Rose

Rose did, by her own account, grow up to have a difficult relationship to her body; one she clearly identified as being shaped by the feelings her parents conveyed to her about her appearance as she was developing sexually. Furthermore, the deeper into familial relationships the interviews travelled, the more obvious it became that negative or critical familial attitudes directed towards the appearance of the body in childhood had significantly impacted upon the ongoing construction of body image for many participants. Rose's account provides but one example. It became apparent as her story unfolded that both Rose's parents felt shame about their daughter's changing body, and the more they attempted to control and contain her body the wider the rupture between her body image and her self

became. Rose's most disturbed feelings about her appearance had their genesis in puberty when she gained weight, a common phenomenon among adolescence girls:

My self-esteem, now at fifty, is better than it has ever been in my life. I had very poor self-esteem as a teenager because I got very overweight. And my parents are lovely but they are quite controlling and I was fifteen years old and eleven and a half stone and I am only five feet two, so I was very fat. So they took me to the GP and he said, "*Right*, she has to be restricted to a thousand calories a day." And he gave me a slimming tablet that I later found was considered a dangerous drug, basically an amphetamine. And mum and dad counted my calories for me. Everything was weighed and counted. And I dropped from eleven and a half stone to nine stone in a very short period of time. This drug affected my sleep for many years. When I had lost the weight that the doctor and my parents considered was good for me, they took me straight off this medication. The withdrawals were shocking. And then we had a small celebration: congratulations, cuddles, dinner. And after the meal, while mum was getting the washing up ready, I went through to the toilet and I put my fingers down my throat and vomited everything up. For twelve years after that I had severe bulimia. All through my first marriage ... Whenever I have trouble in my life the compulsion to binge eat and bring it all up has returned, because it's a control thing. I do believe bulimia is about control and when everybody else is controlling your life or you can't control it, you *can* control what you eat and what you keep down (Rose, original emphasis).

As Elias (1978) elaborates, self-control, internal restraint and mastery of the body are the cornerstones upon which contemporary notions of selfhood, subjectivity and participation in society have been socially determined. As was mentioned earlier the modern idiom 'being out of control' has connotations of instability, madness and a danger which may require removal from the mainstream. Appearing to be 'in control' of one's body is a prerequisite for social inclusion. In a small qualitative study of body builders I undertook as an undergraduate I interviewed a man who made a similar claim: doing body building was a means by which he felt he gained control in his life. He too claimed that many factors external to him gave him the impression that so much which surrounded his life was well beyond his personal control. He believed that controlling his own body by making it stronger gave him the feeling he was in control of his life, in line with Rose's comments above. Moreover, other participants also alluded to past episodes in their lives when they felt 'out of

control' and, while they may have been alluding to shame, few actually used the term to describe their experiences.

Control at the level of the body is a theme that is repeated throughout Rose's interview. By her own account her parents were 'controlling': they enlisted the institutional support of their family doctor, they monitored her caloric intake, they decided if and when she would take or cease medication and when she might stop dieting. Symbolically, Rose was excluded from the most communal of familial rituals by being given separate food which had been apportioned by others who determined what and when she could eat. This impressed upon her that her body was unacceptable, beyond her own control and required management by others. At the same time she negotiated the transition to adulthood she was infantilised by her parents and her doctor. While she was out of control she was displaced to the edges of family life. Moreover, she was welcomed back, overtly loved, approved of and made to feel special when she had lost weight - when she is thin. Contrary to the good intentions of her parents, their approval appears to have been conditional on a number of things: namely, her appearance was to be maintained and the visible display of her self-control sustained. Desperate to maintain the ideal her family had defined for her and, more importantly to retain their approval, she resorted to a strategy of secret purging. Bulimia presented Rose with an alternative way in which she could manage her food intake and maintain the slenderness her parents demanded of her. Silberstein, Striegel-Moore and Rodin (1987) observe that being fat and the subsequent strategies which women embrace to sustain the ideal of thinness are both deeply shaming. Spiralling out from the initial shame of being overweight, bulimia too is considered to be a repugnant and shameful behaviour. As a consequence it is almost always secretive. Bulimia allowed Rose to feel that she was in control of her weight but it came at a great cost to her health. Laceration of the oesophagus and internal bleeding are potentially dangerous side effects of bulimia nervosa. Twelve years of secretly purging much of what she ingested damaged her oesophagus but the timely intervention of an astute doctor and the help of a psychiatrist enabled her to break her pattern. She will require medication to manage a potential decline in her health arising from the fragility of her inner organs for the rest of her life. Despite the seriousness of these events, Rose's dissatisfaction with her body image is ongoing and far from resolved. Throughout the interview she returns

to the issue of her weight with comments such as: 'My weight is a major issue in my life and it is a constant source of discontent ... I'm either loosing weight and happy, or I'm not and I'm unhappy' (Rose). Rose's body image is a source of unrelenting conflict that pits self against body; a desiring, imagining self which demands the subordination of her recalcitrant, uncooperative flesh. Her sentiments were far from unusual in this study. The issue of weight was thematically salient and the frustration that Rose expressed was repeated by many participants, and I will return again to this subject. For now I wish to continue with Rose's experience of growing up as her account illustrates the vast shame which her parents directed towards her body and how their shame came to be internalised as her own. Her father's discomfort with the developing bodies of Rose and her sisters was evidenced by the dress code he imposed upon them.

My father knocked on our bedroom doors from a very early age. There was no nudity in our family from a very early age ... we had to be fairly well covered up all the time ... we were not allowed to come to the breakfast table or out to watch television without a bra on. I *had* to wear a bra. So I used to but a bra on over my pyjamas and then put a dressing gown on over the top; because *I was not allowed* in his presence without a bra on (Rose, original emphasis).

Foundational undergarments, from bras to corsets and girdles, have defined and restrained feminine corporeality in alignment with prevailing, socially constructed ideals of the preferred female form for many centuries (Yalom 1997, Latteier 1998), but Rose's account suggests that her father's insistence on his daughters wearing a bra at all times was a far more localised expression of his control over their bodies. His actions may have been motivated by extreme modesty, but their effect was to reaffirm to Rose the impression that her changing body was something to feel ashamed of. Furthermore, her mounting shame was reinforced by the attitudes of men, strangers she encountered in her day-to-day life, who assumed the right to publicly evaluate her appearance. Throughout her teens Rose found that her breasts brought unwanted attention which left her feeling tainted and reinforced the discomfort she was steadily accumulating towards her body image:

I hated the way that men perved. If I walked past a building site, you know, I would get wolf-whistles and things that they are not allowed to do anymore ... I can remember one day walking

past a car with young blokes in it and one of them yelled out the window “Hey, come over here and sit on my face.” And I just kept walking, thinking “I’m not even going turn around.” So then they drove alongside me and made really awful comments about, (she shudders audibly, automatically) my big breasts. And yes, it really used to bother me (Rose).

Rose was eighteen when she first approached a cosmetic surgeon to have a breast reduction. She was still living with her parents and made an appointment with a cosmetic surgeon without their knowledge. She had never exposed her breasts to another person in her life. She described the encounter:

I was working by this stage and I went to see him (the cosmetic surgeon) and I had to sit there with my breasts exposed and I remember thinking “*This is horrible, this is horrible.*” And he looked at me. He was looking at me and got me to lift my arms up and all this sort of thing. Then he said, “I’m not prepared to operate on you. When you have had your children I would be more than happy to do so.” Then he said something like, “I realise that you are not happy with your breasts because you feel that they are too big; but,” he said, “you have beautiful breasts and I would not operate on them.” Then he showed me photos of women, without their faces, that he had done surgery on, and he said to me, “You should be thankful that they are (beautiful) and I *won’t* operate on you at this stage of your life.” So that was that (Rose, original emphasis).

Rose accepted the surgeon’s professional advice and put the matter to rest. It needs to be acknowledged that this instance provides an example of how cosmetic surgeons can potentially reinforce positive body images in those who seek their services without suggesting a surgical option. Cosmetic surgery, by nature of the theoretical underpinnings of its enactment, reinforces the very simple edict that unaltered appearances are inferior and can only ever be optimised, or at least made acceptable, with surgical intervention. Another participant reported a similar experience when she re-presented for additional surgery after having had an abdominoplasty. Her surgeon felt that further intervention would not improve her appearance and his positive feedback enhanced her body image to such a degree that her desire to proceed with further surgery subsequently dissipated. These two events were somewhat unusual in this study but they are nonetheless significant as they demonstrate

alternative, non-surgical ways in which cosmetic surgeons might use their specialist services to help women resolve and improve their body images. For Rose it would be another seventeen years before she sought the services of a cosmetic surgeon again, to undertake facial surgery in her mid-forties following the dissolution of her marriage.

Rose's account of her childhood experience illustrates how the relationship between the feelings of implied shame conveyed by her parents' attitudes were reinforced and reconfirmed by men around her who viewed her body in critical and, at times, lewd ways, and how these attitudes came to be internalised as her own shame. Her experiences suggest the theoretical concept of figuration (Elias 1978) may be useful in understanding socialisation processes and, in particular, how we arrive upon notions of self and body, and how these in turn might be inflected with shame. The figuration attempts to both link and locate individuals within broader social structures. Rose experienced her distorted body image as something deeply personal but it is clear that interactions with those around her were influential in bringing her to such conclusions. The attitudes of her parents were clearly significant but as she herself observed their intentions were informed by wider belief systems. Whereas the parents Von Raumar (in Elias 1978) addressed were guided by religious doctrine, Rose's parents were guided by its successor, institutional medicine. Her family, the doctor and others with whom she interacted represented the figurations which tied, wove and enmeshed Rose within wider social structures, which in turn informed and shaped her individual experience. Yet the manifestations of shame they induced were contained, concealed and hidden as a personal experience. This relationship between the early familial experience of embodiment, gender and shame emerged as a highly significant theme in this study. Another participant who described how her early life experience was implicated in her enactment of cosmetic surgery was a woman I have named Jenna. Although some aspects of Jenna's account were thematically salient across other interviews, her childhood experience and the way she engaged cosmetic surgery were amongst the most confronting presented in this study.

Jenna

Jenna, like Rose, sought a breast reduction while still in her teens. Her formative experience in childhood had lasting impacts on how she viewed her own body. She had a breast reduction at sixteen and encouraged her daughter to have her breasts reduced when she was also sixteen years old. Jenna's account suggests that she felt considerable frustration and fear about the symbolism with which her breasts were imbued and, using her own experience as a gauge, considered this to be a positive intervention on her daughter's behalf. From the beginning of her interview it became clear that Jenna had had a complicated life: an abusive childhood, married and divorced twice to men she described as 'control freaks,' estrangement from her parents, siblings, her children and grandchildren and, at forty five years of age, she had undergone multiple cosmetic surgeries. Jenna was the most prolific consumer of cosmetic surgeries to take part in this study and, perhaps not insignificantly, gave the most devastating account of her early life. She had her breasts reduced twice, an abdominoplasty and liposuction to various parts of her lower body. Her most recent surgery had been a facelift, done just three months prior to our interview. She was planning cosmetic dentistry in the near future. Jenna described an ongoing and problematic relationship with her body and body image which included a history of eating disorders, diuretic abuse, ongoing bowel problems stemming from long-term laxative use and she suffered from recurrent depression and anxiety disorders. Panic attacks and depression had ensued in the wake of her most recent surgery and she had resumed antidepressant medication which she felt had provided some improvement and had enabled her to return to work. Jenna had little in the way of financial resources but she had saved for her facelift. However, she was pushed into debt when her cosmetic surgeon decided to perform additional procedures which he recommended just days before her surgery. As is common in many cosmetic surgery practices, she was required to pay for her surgery beforehand. Jenna was not happy to go into debt but was persuaded by her surgeon's argument that the additional procedures he proposed would give the optimum result.

Jenna endured incest from nine years of age and understood this to be a central source of instability to her life. When children are sexually abused they do not always understand the events or their implications immediately, particularly when the person involved holds a

position of trust. This was the case for Jenna when her older brother began violating her: at nine he traded an ice cream for her body and her silence. Like the experience of two other women in this study who spoke of childhood rape, Jenna's mother could neither hear nor believe what her daughter was telling her and accused her of fabricating stories. Childhood sexual abuse and rape are established social conditions implicated in the manifestation of shame (Lewis 1987:5a, Morrison 1998:197) but the silence of these mothers compounded the virulence of that shame which continued to affect the body image of each of these women. Here silence conspires with shame to conceal that which is abject and cannot be faced. It was the gradual realisation she had been defiled that has lived on within her, along with an ongoing dread that her body had betrayed her. For Jenna these violations were unresolved injuries; old wounds, silently suppurating and polluting her sense of selfhood long after their inception, a seminal rupture she struggled to heal, much less close. To borrow a metaphor from Arthur Frank (1995), Jenna was a wounded storyteller. As an adult in her thirties she felt compelled to resolve the issue through the courts where her brother was found guilty of incest, but this did not bring the closure she had hoped for and inadvertently cost her the support of her family. Mortified and deeply angered by the public airing of their darkest secrets, Jenna's family denied the court's findings and subsequently excommunicated her following a violent altercation. These events had taken place over five years before her interview but, like opened floodgates, Jenna spoke for close to an hour on the subject, one still so painful and unresolved, before I broached the subject of cosmetic surgery. Sequential betrayal and rejection flow through her story and on each painful occasion cosmetic surgery was sought as an attempt to assert some semblance of self-control, an appearance of dignity; but more than that, her surgery, as with the purging and emptying characteristic of bulimia and laxative abuse, might be understood as attempts to cleanse her spoiled body. When Jenna spoke of her breast reduction at sixteen it was clear that the sexual changes inaugurated by puberty confirmed the sense of danger, implicit in the shame experience which she felt her body elicited. Not wanting her body to betray her again, she sought to eliminate contingency and reduce anything that might heighten her sexual attraction to men. It was 'because of all the sexual abuse, I wanted to take away that sexy look ... I didn't really care at the time; I just wanted to get rid of the breasts' (Jenna). She did not say *my* breasts, but *the* breasts. After two breast reductions Jenna continued to speak of her breasts as external objects, not as

something which was part of her. After two breasts reductions she appeared unable to integrate her breasts into her preferred body image or sense of self.

Jenna had so many cosmetic surgeries that she began to question her own motivations in seeking surgery. She suspected that cosmetic surgery had become another form of abuse which she now self-inflicted. She believed there was a connection between her sexual abuse and the amount of cosmetic surgery she had had. The abuse inflicted by another upon her body had been internalised as a form of abjection which she continued to enact out upon herself: 'the person that's abused ends up abusing themselves in the end' (Jenna). She saw 'chopping her body up' with cosmetic surgery as part of a continuum of profound disembodiment initiated by the sexual abuse from her brother. He, and then her 'control freak' husbands had undermined her self-control. She had, in turn, used cosmetic surgery as a way to regain control over her own body. Along with the possibility of taking control of the self, cosmetic surgery suggests other possibilities in making perfect that which she clearly believed was not. Jenna's relationship to both her body and how she used cosmetic surgery were highly complex. She explained:

I think I became a masochist to myself ... With all the abuse I started abusing myself. I was unhappy with myself. I didn't think I was good enough and I wanted to be perfect. Most sexually abused children with low self-esteem want to be perfect, or they end up being perfectionists, and I guess I fell into that category. Whenever I worked I had to be the best at everything. Um I, I had to appear (perfect) ... It's just that perfection role you put on yourself (Jenna).

Jenna, more than any other participant, came to interview with a clearly articulated agenda. On the very first occasion we spoke by phone she said she wanted to take part in this study because she wanted others to hear her experience of cosmetic surgery. Frank's (1995) wounded storytellers write their illness memoirs to reclaim their own embodiment. They memorialise their illness experiences as final, altruistic acts to offer an alternative view of life and death to that proposed by medicine, so that others in similar circumstances may draw inspiration and understanding from their accounts. While Jenna was clearly not at the end of her life, her motivation to tell her story did share similarities with Frank's wounded

storytellers. She too wanted others to understand that the reasons people choose to have cosmetic surgery can be much more complicated than the simple motivation of vanity which is frequently assumed. Participating in this study was part of an ongoing quest she felt compelled to undertake to make sense of her own history and the way the threads from her past continued to inform her current experience of embodiment. Other participants also engaged the interview as an opportunity to discuss the particular circumstances informing their embodied experience and the role cosmetic surgery had come to play in that experience. Many came to the interview prepared; they had pre-empted my questions and revisited their reasons for having cosmetic surgery, and they used the interview to order their thoughts and reflect upon issues that are not easily spoken about in everyday conversations. This is perhaps because stories of the body, its appearance, management and the measures undertaken to resolve these difficult relationships are deeply personal and easily tainted with notions of superficial egotism. They are also deeply shameful. Shame is one of the most prolific, yet difficult and subterranean experiences to access. It is raw, painful and uncomfortably familiar, yet shame lies hidden beneath our social structure and that is where most of us would prefer it stayed.

Elias (1978) defines shame as a relationship between the embodied individual and the social group, where the breaching of socially prescriptive rules around the subjective management of corporeality carries with it potential sanction. He describes shame as emerging from within particular historical and demographic shifts that have transformed social life and seen human interaction increasingly inhabit closer physiological proximity. Concomitant to these processes has been an increased emphasis and certainty on visual perception and, with it, a heightened anxiety regarding the appearance of the body. Elias illuminates the legacy which these processes have bestowed upon the modern experience of embodiment, particularly in relation to notions of control and self-mastery at the level of the body, and the subsequent experience of anxiety he defines as underpinning the phenomenon of shame informing contemporary embodiment. Emergent within these processes have been the increasing definition and prescription of particular forms of embodiment which he exposes as reinforcing a punitive social order where the onus of conformity has fallen upon the individual. Elias' conceptualisation of shame highlights compliance with the collective rules

of corporeality and the individual desire for acceptance as centrally important to the internalisation of shame. His theoretical contribution focuses on macro-social processes with a clear eye to how they impact upon the lived experience of the individual, and although he takes the vulnerability and anxiety experienced by the individual constrained by shame as his starting point, his concerns lie with deciphering how historical momentum and the cumulative effect of wider social processes have created these anxieties. Any questions relating to the way shame is experienced, how it emerges within contemporary female subjectivity at the messy margins of the material body and, more importantly for this study, how it is resolved, require further elaboration.

Jenna and Rose grew up feeling intense shame around their bodies, that their bodies were dirty or spoiled and beyond their control. Their anxieties around body image were significantly influenced by early childhood socialisation and those experiences became part of the experiential bedrock upon which subsequent experience was built and developed. As adults they continued to experience their bodies through ambivalent psychodramas played out in their private realms where their recalcitrant bodies were both admonished and admired by their punitive evaluating selves. Elias (1978) takes us a good part of the way in understanding how shame has come to be a significant feature of modern psychosocial experience, something which regrettably few other sociologists to follow him have attempted, so this important introductory work has not been developed, particularly in relation to women. Consequently, we must look further afield to understand the specific experience of female embodiment with relation to shame in order to more accurately reflect and explain the experiences of participants taking part in this study. At this point it is useful to consider the language which participants themselves used to describe their pre-surgical bodies and the surgeries they engaged in.

Shame and dirt

Invoking the descriptor of 'dirty' to describe the experience of inhabiting a body which appears flawed was used by some participants in Davis' (1995) study. The contention that shame around the female body is linked to notions of 'dirt' was also made explicit by Rose and was implied by others who took part in this study. As one of the options available to

them to resolve the shame they felt towards their bodies, both Rose and Jenna, and indeed most other participants, described a process of imaginatively demarking, excising and casting aside the source of their shame as they rehearsed their post-surgical bodies. We see in this context relating to body image the beginning of what might be called a shame sequence. Following Cooley (1964) self-evaluations are influenced and informed by the views, whether real or imagined, of others. Feelings of shame emerge from an awareness that bodily appearance has been evaluated as unacceptable by one or more significant others and, in turn, such views are internalised and accepted by the self. As a consequence, the self comes to view itself as inferior. In this formulation there is a notable slippage from faulty body image to faulty self and more will be said about how these processes are interrelated when psychoanalytical conceptualisations of shame are considered in the next chapter. Implicated in poor self-evaluation is the realisation that social exclusion might result. Being shamed demands action to restore the acceptability required to re-enter and participate in the social group and it would appear that cosmetic surgery as a modern grooming technology is employed to fulfil this functional capacity. Through the language appropriated by participants to describe their pre-surgical bodies and their subsequent surgeries it would appear that cosmetic surgery might also be understood a form of ritualised grooming, as an enactment employed to both control and cleanse a body whose appearance is deemed, by both evaluating self and consulting surgeon, to be inferior.

Talking dirty

There is a litany of terms ('tidying up,' 'nipping and tucking' and the current favourite 'freshening up') to be found in the vocabulary surrounding everyday discussions of cosmetic surgery. These terms were used by participants and cosmetic surgeons alike to describe and communicate what cosmetic surgery might offer to prospective patients. By virtue of their implied meaning such terminology suggests that women's bodies are dirty, disordered and tired. However, rather than raising the ire of indignant women the world over, the use of these terms has perhaps achieved a more devious end. By appropriating the everyday, overtly prosaic language of domestic management where women have traditionally exercised domination, cosmetic surgeons have not only physiologically groomed their patients; they have discursively groomed them (for further discussion see Sullivan 2000, Woodstock 2001).

This linguistic sleight of hand in effect conflates and aligns the bodies of women with the domestic setting and promulgates the notion that the bodies of women can be controlled and managed like they themselves manage their homes. This terminology, while seemingly innocuous and familiar, contributes to a wider design which has seen cosmetic surgery progressively normalised as a grooming practice, while obfuscating the potential seriousness of the long hours of anaesthesia and surgery which such enhancement frequently entails.

While participants readily used domestic euphemisms to describe their surgery, one participant who had abdominoplasty used the metaphor of dressmaking to explain how, in the formative period prior to surgery, she had imagined the surgical process would remove unwanted flesh from her lower abdomen. She recalled standing in front of the mirror and literally separating the superfluous mass, which she had previously described as a 'tumour,' from her lower abdominal area and imagined how she would look if it were no longer there. This area of flesh represented what she could not control, an untidy, repulsive part of her body which made her appear bigger than she wanted to be. She described gathering the unwanted part of her body and encasing it in her hands. Her thumbs and fingertips came together and she imagined a potential suture line:

Well, when you've got such an obvious hanging thing there, this growth, it's a physical thing to put your fingers around it and feel that this piece of skin could meet with this one and I could do this. And I don't know whether it's the ability to sew or anything, but consciously you can picture how it's done. Before there is any explanation by a doctor, you can see that if you ran a line of stitching along here you could cut this (excess) off. That it would make you smaller. And it would be gone. And that's in your mind, not that you are about to self-mutilate and do it, but when you look at it and see that technically this could be done, very simply ... from here to here (she places her fingers on both her hips). Like you take a dart in, and cut off the excess (Allie).

By appropriating the familiar, the domestic, Allie aligned dressmaking with cosmetic surgery to make tangible a modified version of her potential body image. For Allie, comprehending how her surgery might be technically accomplished meant that having an abdominoplasty became an increasingly 'do-able' proposition for her personally. While this rehearsal

enabled her to envisage how her appearance might change if she underwent surgery, it also illustrates how she domesticated cosmetic surgery and, in effect, normalised the process. By assimilating cosmetic surgery to tailoring she demystified surgical technique so that it became something knowable and altogether more familiar. In her imagined fantasy before the mirror she marked, separated and imaginatively re-defined the topography of her body into zones of potential inclusion and exclusion. She nominated what could be jettisoned- that which she cannot control, that which will make her smaller. People who experience shame also frequently experience the feeling of wanting to disappear. For bigger women, feelings of shame stem from their bodily size and are evident in their consistent desire to become smaller (Stilbertin et al. 1987:91).

For Allie, her 'hanging thing' was matter out of place. She identified it as superfluous but it was also something shaming which inhibited her self-acceptance. In the private rehearsal before the mirror which she described, Allie increasingly came to view that part of her body as an object which was external to her self. In her imaginative ritual and utilising her own knowledge, Allie came to envisage her body re-contoured. This occurred long before she visited the cosmetic surgeon, but in planning her surgery her actions suggest that she had imagined and introjected his gaze in re-viewing her body image and its potential for surgical amendment.

The processes which Allie used to imaginatively delineate the margins of her post-surgical body share unmistakable similarities with the pollution rituals studied by the anthropologist Mary Douglas (1966). Douglas looks to the domestic sphere to determine what everyday practice might reveal about the way social rules regulate the margins of the embodied and social world and what they might in turn disclose about wider social processes instigated to enact order and control. In correlating the pollution rituals of many cultures, from indigenous to modern, Douglas determines that while what is considered 'dirt' is always culturally specific, the underlying processes of classifying, defining and ordering, both the body and the social space it inhabits, into the demarcated categories of clean and dirty is ubiquitous. Douglas develops the notion of 'dirt' as 'matter out of place' coined by American pragmatist William James (Douglas 1966:164) to illustrate the way in which

control is enacted over the natural world by practices of inclusion and exclusion designed to establish order. When it comes to the body, Douglas understands it too to be a border, perforate and penetrable, around which the embodied transgressions characteristic of human experience are subjected to a myriad of rules and rituals instigated to establish and maintain order. Douglas writes:

I believe that ideas about separating, purifying, demarcating and punishing transgressions have as their main function to impose system on an inherently untidy experience. It is only by exaggerating the difference between within and without, above and below, male and female, with and against, that a semblance of order is created (1966:4).

Douglas (1966) makes clear that through enacting ritual we preserve the sanctity of binary classification, sustaining order upon the unruly body as well as preserving systemic hierarchies existent within the social world. She shares with Elias (1978) recognition of the body as a site of social significance upon which a symbology inherent within social structure is overlain. Both Douglas and Elias observe regulation around the body and confirm the existence of underlying interpretations of the body as unruly and requiring control.

For Douglas (1966) defilement, contagion and dirt are metaphors for that which defies social order. It is through processes of cognitive differentiation that dirt is identified and marginalised. In the course of establishing order dirt becomes that which is rejected, that which is abject (Kristeva 1982). Dirt, then, is the by-product of social order, but dirt, in and of itself, is meaningless, and it is only in relation to a border or margin that it becomes significant. Douglas identifies a two-stage attitudinal process in which dirt is identified and subsequently rejected so that order may be restored. Firstly, what is rejected is 'recognisably out of place, a threat to good order and so ... regarded as objection and vigorously brushed away' (Douglas 1966:160). Dirt must be identified, separated out and accorded a partial identity, 'But a long process of pulverising, dissolving and rotting awaits physical things which have been recognised as dirt' (Douglas 1966:160). In other words, dirt, once it has been removed, becomes waste. It is only when dirt no longer has any identity, and is finally undifferentiated, that it no longer represents any threat: 'Where there is no differentiation there is no defilement' (Douglas 1966:160). Here in the 'creative formlessness of dirt'

(Douglas 1966:161) reveals its symbolic power, but it is in the first stage that its force is recognised as potentially destabilising to established order. Douglas makes a number of relevant points: dirt, filth or defilement is only meaningful in relation to a boundary, and boundaries themselves function to enforce classificatory structures relating to inclusion and exclusion. Moreover, the quest for purity is established in relation to rejection (1966:161). At the level of the material body Douglas (1966:121) cautions that it is a 'mistake ... to treat bodily margins in isolation from other margins.' Upholding margins and the rituals enacted to preserve them serves other purposes in managing and controlling collective social experience.

The rituals enact the form of social relations and in giving these relations visible expression they enable people to know their own society. The rituals work upon the body politic through the symbolic medium of the physical body (Douglas 1966: 128).

Rehabilitating the defiled and cleansing the impure requires specialised ritual. Douglas (1966) writes that power resides with those who hold the ritualistic power to purify that which has been defiled and restore order to that which is disordered. At the level of the woman who instigates cosmetic surgery and the surgeon, along with the attendant ritual embedded in their practice, dynamics of power and order are invoked. She believes she is exercising her right to enact power and agency over her transgressive flesh as a way to re-establish order to her disordered body, to rehabilitate her shamed status and rekindle hope for an improved life, while the cosmetic surgeon holds the power to define what constitutes disorder at the level of female appearance and to enact transformative change.

If the language of domestic management surrounding cosmetic surgery and Douglas's (1966) theoretical conceptualisation of dirt are reconsidered we are in a position to suggest that cosmetic surgery, particularly where tissue is removed, is a type of pollution ritual, a form of ritualised cleansing or grooming. The substantiation of this proposition is made clear by another participant account where the process of physiological differentiation put forward by Douglas is unambiguously articulated. Amanda, like Allie, sought an abdominoplasty in the aftermath of massive weight loss. Her efforts to reshape her body through exercise failed

dismally and Amanda was left with an area across her lower abdomen that she, through the course of the interview, progressively came to refer to as 'it.' She recalled how she redefined the boundary of her body in the period before she had surgery. 'It' had indeed been part of her but by the time she decided to have surgery she, like Allie, had already imaginatively excised 'it' from her body image.

I felt like this odd and freaky woman with this stomach that moved all by itself ... One of the worst things was climbing stairs, I could hear it flapping up and down. It actually had a physical presence of its own ... and I used to think, "What am I going to do with it?" It was actually no longer part of me- "I don't want *it* and I don't need *it* and *why, why won't it just go*" (said with frustrated dismay). And it was never going to go, and I suppose it took me a while to realise that. There was a point where I had to say, "*I need* to do something about this because it will not go without me doing something about it" ... I used to pick it up and I used to look at it, and hold it, and think, "*Oh my God*" (again said with dismay). And I actually asked the surgeon who ended up doing the surgery how much it weighed. 'It' took on its own ... (long pause as she searched for the right word) ... not persona ... but 'it' was an 'it,' and that 'it' was going to go. And I loved the idea. I would pick 'it' up in my hands and think: "Soon, you are going to be in a bucket." I did. And the surgeon who I ended up *commissioning* to do this job for *me*, which is very much how I ending up thinking about this surgery, we used to joke about 'it' and how much of 'it' was going to go in the bucket ... 'It' ended up weighing three and a half kilos, which is quite a bit (Amanda, original emphasis).

Amanda was not alone in quantifying how much a surgically excised area of her body weighed. It is not an unusual surgical practice for the volume of blood lost by patients during surgery to be measured. Such information alerts medical caregivers to potential compromise in the post-surgical phase, and it appears that cosmetic surgeons also weigh the skin and tissue they remove since many participants reported by weight, or by volume in the case of liposuction, the amount which had surgically been removed. This was presented as a form of evidence, as a way of confirming the superfluousness of what had been removed and affirming the agreement between surgeon and client: indeed, what had been removed was no more than waste.

Amanda and Allie's experiences of marking out their bodies into zones of inclusion and exclusion were in no way isolated, as many participants described similar processes in the period before they had surgery. Indeed, at the very beginning of this study, as I immersed myself in reading and imagining what it might feel like to want to have cosmetic surgery, I too found myself pulling areas of my own face around, imagining the changes that surgical excision might bring. These behaviours, enacted by myself and my participants, resonate with the conceptualisation of dirt which Douglas (1966) proposes and are helpful in providing an understanding of the way women who undertake cosmetic surgery come to review, fragment and re-evaluate their body image in the period prior to undertaking cosmetic surgery. Furthermore, as will be explored in the next chapter, when the subjective experience of shame is considered in more detail, shame is more complicated than loathing one particular body part. Shame occurs when the loathing of one bodily region extends to derogate the whole self and inflame an angst-ridden conviction that one's appearance is so flawed it will almost certainly invite rejection. In private, micromanaged ritual between self and body image participants rezoned their bodies by demarcating that which is superfluous, unacceptable and beyond their control. Douglas suggests that private bodily ritual reflects the symbology inherent within broader social structures. In the shame experience the offending body part is seemingly managed in the body/self dialectic, but shame threatens to inflict the whole self with a feeling of worthlessness, engendering within the self an overwhelming fear of social exclusion. Zygmunt Bauman (2004) extends the model proposed by Douglas to suggest that individuals in contemporary societies live with an ever increasing fear of being marginalised as unviable social participants; a category he nominates is increasingly being viewed as human waste. Fear of social redundancy threatens shame, and it is to this fear that cosmetic surgery speaks.

By engaging the work of Norbert Elias (1978) I have attempted to argue that shame is conceptually significant in understanding the complex nature of contemporary embodiment. Although Elias' work advances sociological understandings of the dynamic role which shame plays in the psychosocial nature of embodied experience, his work is limited by a number of omissions. Elias describes and identifies shame as significant to subjective experience. He contends that increasing anxiety surrounding the management of the body

and the subsequent fear of social exclusion which a faulty body might elicit are central to the self-monitoring characteristic of the shame experience. He also observes that the role the family plays in socialising corporeality as a significant site from which shame emanates, but he does not explore how shame might be experienced at a subjective level. Elias only briefly considers the ways in which gender might be implicated in the shame experience, but it is from his observation of the instruction advising parents on how to inform their daughters of their reproductive function that similar themes were correlated from the present study. By comparing Elias' observations with themes found in the data, an overlapping of shame and dirt emerged as relevant to the discussion of cosmetic surgery. These themes were further confirmed by a brief perusal of the lay language drawn from domestic management which dominates prosaic discussions of cosmetic surgery. By developing upon the notion of 'dirt' as a descriptive category of the flawed female body observed in participant accounts, correlations were then made between the way participants came to view their bodies as flawed, and in need of surgical amendment, and the pollution rituals theorised by Douglas (1966). Utilising Douglas' insights enables an illumination of the very private ritual of fragmenting and demarcating the body which is undertaken in the imaginary reconstruction of a preferred body image enacted in pre-surgical rehearsal. By engaging with these theorists I have attempted to develop an understanding of the intimate relationship between femininity, flawed flesh and how they are implicated in, firstly, the experience of shame, and then the enactment of cosmetic surgery. However, these explanations fall somewhat short of constituting an extensive exploration of either shame or cosmetic surgery. Following in the footsteps of other sociologists (for example Lynd 1958 and Scheff 1988, 1990, 2003) who explore shame in detail, the next chapter considers the contribution which psychoanalysts have made to understanding shame, with a view to explaining how the process of evaluating body image as flawed impacts upon self-experience. It is my contention that engaging relevant theorists from this milieu enables a deeper sociological understanding of shame and how it is subsequently implicated in the fragility of body image and the enactment of cosmetic surgery.

Chapter Five: Shame and Subjective Experience

For sociologists stigma is a familiar concept largely made accessible through the work of Erving Goffman (1974). Developing the trajectory of Cooley's thought, Goffman (1969) has further elaborated that the staged dimensions of human performance have their own regulatory codes, whether written or merely implied, vested in upholding the moral values instituted by the social group to whom the public visage of performance is directed. In his introduction to *Stigma: Notes on the Management of Spoiled Identity*, Goffman (1974) observes that the original meaning of stigma, articulated first by the ancient Greeks, referred to visible markings inscribed on the bodily surface. These inscriptions were brandings on flesh which warned of specific moral breeches of character: 'signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal, or a traitor – a blemished person ritually polluted, to be avoided, especially in public places' (Goffman 1974:1). Later Christian meaning added skin lesions to the definition deeming them to be embodied manifestations of holy grace, upon which medical meanings overlaid notions of physical disorder. While contemporary definitions of stigma have extended beyond what is corporeally visible to include blemishes of character and racial or religious affiliation, it remains the case that the appearance of the body is always subject to evaluation and sanction.

Goffman introduces *Stigma: Notes on the Management of Spoiled Identity* (1974: xi) with a letter to the agony aunt, Miss Lonelyhearts, by a sixteen year old girl born without a nose, who signs her letter '*Desperate.*' The reader is left with little doubt that participation in a regular social life commensurate with that of her peers is something she will be denied. Grappling with her parents' sense of helplessness and rejection by potential suitors, she is at the point of contemplating suicide. Social death and actual death are imminently convergent and underline the high stakes breaching societal appearance norms might involve. This letter remains deeply moving and provides a poignant example of the mortification that flawed bodily appearance can elicit. The strategic placement of this letter suggests that Goffman (1974) understood and indeed empathised with the despair which agonisingly poor body image might engender. He clearly alludes to darker territories of self-experience invested in the issue of physiological appearance where the price of a flawed appearance might entail

social exclusion, but the elaboration of stigma as a subjective experience is something he only touches upon. Similarly, in earlier work on interaction rituals, Goffman (1967) argues that all social encounters are potentially prone to embarrassment and subsequent disorder. He goes on to list and forensically examine the myriad strategies which people consciously and unconsciously employ to ensure the restitution of social order that embarrassment threatens. While the avoidance of and recovery from embarrassment are clearly important in face-to face-interaction, Goffman's interest remains at the level of observable human behaviour and the structures they institute, and he offers only limited insight into the motivations underpinning these behaviours.

Writing at the end of the nineteenth century, William James (1950) also gives an evocative description of the hypothetical despair the redundant 'social self' might feel. He contends that the social self is innately dependant on being noticed favourably by others in face-to-face interaction, confirming favourable social interaction as integral to the very notion of subjectivity. James does not discuss physical appearance specifically but his demonstrable understandings of the unworthiness registered by those who feel socially excluded resonate with the experiences of "*Desperate*" (in Goffman 1974) mentioned above. They also echo the sense of invisibility and social redundancy experienced by the women in this study who felt compelled to undertake cosmetic surgery to amend their appearances in line with a more culturally and socially acceptable form. James' insights concur with Goffman's thesis that bodily appearance remains central to the representation of the self, particularly in face-to-face interaction, but he goes further to suggest that the impact of ensuing evaluations, exquisitely sensed in interactive feedback from others, potentially shape both the trajectory of the social encounter and subsequently inform assessments about the self-worth which the self will make in reviewing its own performance. James writes:

No more fiendish punishment could be devised, were such a thing physically possible, than one should be turned loose in society and remain absolutely unnoticed by all the members thereof. If no one turned round when we entered, answered when we spoke, or minded what we did, but if every person we met 'cut us dead,' and acted as if we were non-existent things, a kind of rage and impotent despair would ere long well up in us, from which the cruellest bodily tortures

would be a relief; for these would make us feel that, however bad might be our plight, we had not sunk to such a depth as to be unworthy of attention at all (James 1950:293,4).

Both Goffman (1974) and James (1950) expose the other side of social subjectivity hinting at the dissolution the self might experience when its suspects that it is no longer registered by others as socially worthy. Their insights are highly relevant to themes observed in this study. Implicated in participant accounts of bodily loathing were the dread of social and professional redundancy manifested in the cumulative experience of invisibility generated by an ageing face or a bigger body, by feeling so unattractive as to be unworthy of the love of another, or by not being taken seriously in the work setting. The 'feeling state' (Lewis 1971) engendered within the self is the fear of social redundancy or social exclusion. For James (1950), Goffman (1974) and many others (see for example Douglas 1966, Kristeva 1982, Bauman 2004), the social world is understood metaphorically as a topographical landscape or a geographic construction where borderlines in the form of social rules, laws and, indeed, cultural preference demarcate the parameters of social inclusion and exclusion which are subsequently reproduced and reinforced by individuals in both conscious and unconscious ways. Commonly held understandings of social worthiness are also conceptualised and experienced in line with these same principles which, in a sense, resemble a form of social cartography. Women who took part in this study expressed an acute awareness of where such borderlines had been drawn and a capacity to locate their own placement socially, in terms of whether they felt excluded or included, in relation to how they evaluated their own appearance.

The physiological characteristics most despised by participants in this study, and those for which they had sought surgical amendment, pertained most frequently to weight and ageing. Many spoke of a type of social redundancy, manifested in a feeling of being invisible, or worse, feeling dismissed from particular social settings. Many felt that an ageing or bigger woman ceases to be noticed or considered relevant in the frenetic milieu of contemporary, and in particular, urban life. These experiences were repeated throughout the interviews, ranging from being overlooked for service in shops and restaurants to specific tensions in the workplace; incidents which serve to empirically reinforce feelings of marginalisation on the

basis of gender, age or size. Older women spoke of not being noticed and believing that because they looked older they were no longer deemed relevant. Others spoke of their professional ambitions, countered with concerns about not being taken seriously or considered competent, in the work setting. This was especially pronounced in work environments traditionally dominated by men. Bigger women spoke of the negative evaluation of their presence by strangers. Another spoke of unrestrained abuse from complete strangers. She claimed that derogatory comments from strangers were an everyday reality for bigger people: 'It's a very real thing for obese people, it's not people *might* be rude, *they are* rude' (Sarah, original emphasis). Women in this study understood that body image is a contested domain for many women, but they interpreted their flawed appearance as a problem relating specifically to them; that it was their responsibility to manage the impressions of others rather than nominating a broader system of discrimination which is both sizeist and ageist.

The reparation and amelioration of body image was a central motivator for all participants in proceeding with cosmetic surgery, but their accounts varied in complexity. For a smaller group (5/28) the decision to have surgery was pragmatic and uncomplicated. These women did not describe poor body image as a chronic feature of their self-experience. While unambiguous in their dislike of the particular feature which had taken them to the cosmetic surgeon, these women described their body image as generally good, rather than persistently problematic. They tended to compartmentalise a disliked aspect of their appearances by medicalising it as a genetic anomaly or as physiological change resulting from the experience of maternity. For these women, the dislike for their appearance was limited to a particular region of the body and specific circumstances, seen as something beyond their control, and this appeared to insulate them from the engulfing experience of shame. Shame, as will be discussed, pervades and implicates the whole self. However, this study found that the relationship between shame and cosmetic surgery is complex and, despite maintaining fidelity to their pre-surgical body image, participants from this smaller group were not immune from experiencing shame in the aftermath of having cosmetic surgery. This was evidenced in the measures they subsequently employed to guard the secrecy of their surgeries,

and none could rule out the possibility of having further surgical intervention if they came to dislike a particular aspect of their appearance.

These accounts differed considerably from those of the majority (23/28) of the participants. The most notable point of difference was the complexity of their personal histories and the extent to which poor body image had impacted self-image in the accounts of the latter group. Women from this group also articulated an intense dislike of an aspect of their pre-surgical appearance, but their accounts described body image as a persistent feature of self-image. Participants from this larger group viewed their flawed appearances as affecting, either directly or indirectly, other aspects of their lives. They believed that their ageing faces or rounder bodies hindered their employment possibilities, their potential for intimacy, and their general visibility to others or being taken seriously in the workplace. Chronic fragility around body image was frequently described as a perception that had been acquired in childhood which then persisted into adult conceptualisations of body image. Women from this group described day-to-day interactions as routinely undermining body image. It is helpful to recall Schilder's (1950) proposition, discussed earlier, which emphasises that body image is a complex and multifarious process, and the events which threaten and destabilise it are equally complex, varied and evolve from within a range of social contexts and constraints.

Participants with chronically poor body image explained their cosmetic surgeries by recalling their histories of embodiment. This meant that the field work undertaken for this study was often more confronting than had initially been anticipated. Disordered eating which began in adolescence and continued into adulthood was a prevalent theme. Three women spoke of having bulimia nervosa as teenagers, and eleven spoke of being overweight as teenagers when dieting practices which had continued well into adulthood were first engaged. Separation too was a relevant theme. Eleven women had cosmetic surgery within five years of a relationship breakup. These participants spoke of re-evaluating themselves following the separation as a prelude to seeking out self-improvement strategies. Separated participants spoke of their appearance as a form of physical capital and described themselves as re-entering an arena frequently nominated as 'the market.' Participants (4/11) who had been left for a younger, thinner or more attractive woman were especially vulnerable to poor body

image. Three women spoke of having facial surgery during their recuperation from serious illness because they wanted to appear healthy in an attempt to deflect the concerns and sympathies of others. They sought to excise the remnants of illness and spoke of wanting to look in the mirror and appear well, rather than strained and ill. Evoking elements of the Lacanian (1977) 'mirror stage,' these women looked to their own reflected images, hoping to draw an emanated feeling of subjective intactness. Moreover, they believed that by appearing well to themselves and others they would indeed feel well.

Three women interwove their histories of childhood sexual abuse into their ongoing and problematic quests for embodiment. Sexual abuse pollutes both the body and the self, devastating both self and body imagery for many years after the event. For each of these women the reparation of body image presented ongoing difficulties and challenges. Each told a similar story in which they tried to tell their mother of the event but it was brushed aside and never discussed again. There was an eerie sameness in their stories; the maternal silence had become a second betrayal that contributed to their festering shame. Denied an opportunity to denounce the abuse and demand that the abuser account for his actions, the shame of his stain remained hidden and undischarged within their bodies. A clear connection between cosmetic surgery and sexual abuse was made in the case of Jenna, whose account was discussed in the previous chapter.

Unexpectedly, the subject of suicide was raised in four accounts. One woman's adult child had suicided, as had another participant's sister. Another two women spoke of their partners descending into mental illness followed by suicide. Although I was initially shocked to find myself speaking on such matters in interviews about cosmetic surgery, I became less so as I came to understand that contained within the considerable seductions which cosmetic surgery promises through the reparation of body image is the ritualised amending, transforming and reinvesting of oneself which is required when an episode of life necessitates closure and another phase, with its considerable unknowns and contingencies, is embarked upon. A number of women located cosmetic surgery within a repertoire of enactments designed to demarcate and signify a new episode, or a 'second chance' at life. Significantly, the accounts of participants emphasise that the construction of body image is rarely, if indeed ever, spoken

about as an independent variable. Rather, body image is as Schilder (1950) would have it, manifold, interwoven and impacted by events and encounters seemingly extraneous to the self but, on closer inspection, totally implicated in its construction.

Participants only occasionally used the word 'shame' to describe how they felt about themselves, and rarely spoke of feeling ashamed of their appearances, but as I was to find, their experiences nonetheless shared similarities with those found in theoretical discussions of shame. In the previous chapter the work of Norbert Elias (1978) was reviewed to explore the significant sociological understanding he brings to the study of shame. His work gives shame a central role in the historical and social transitions characteristic of modernity which, he argues, has witnessed increasing constraint surrounding the body. With the increase in individual responsibility associated with the management and control of comportment has come a subtle increase in the sanctions concerning appearance. Consequently, at the level of the individual, an increased level of anxiety and fear surrounding the contemporary experience of embodiment has occurred. Elias identifies these evolving processes as the progressive internalisation of shame. Like Goffman (1974), Elias (1978) recognises individually experienced and embodied stress as heuristically implicated in the concomitant evolution of social structure, but how shame is experienced at the level of the individual is less clear. Even less clear is how shame has been implicated in the experiences of women. It is the intention of this chapter to consider the accounts of several participants as a way to explore how their body image and sense of self are interwoven and might be understood as informed by shame. In reviewing the literature it became clear that the theorists to give the most detailed attention to shame were a small group of psychoanalysts. This chapter will consider select contributions made in refining an understanding of shame, and in particular will consider the highly perceptive work of Helen Block Lewis (1971). Lewis has much to offer in moving towards an understanding of the relationship between gender, body image and shame. I begin with a general introduction to the way in which psychoanalysts have defined shame.

Shame and the self

In contrast to Elias' (1978) social history of shame, psychoanalysts place the self and self-evaluation within the context of social life at the centre of the conceptualisation and experience of shame. Fundamental to the definition of shame which they propose is a particular experience of the self characterised by the notion that the self is defective, flawed or failing in some way. In the first instance, shame is about the experience of the self and how the self imagines itself to be. In *The Culture of Shame* (1998), Andrew Morrison describes shame as the discrepancy between the image we have of ourselves and the ideals and convictions we believe our selves should present. Viewed in this way shame emerges from the gap between what we think we are and what we hope to be; it emerges, then, from a fault line between self-perception and social aspiration.

The parameters of shame are carved out in the social domain but shame is felt as a devastatingly painful and deeply personal experience. Shame is characterised by the feeling of being singled out and exposed in ways that are unfavourable and unflattering, followed by the desire to conceal the weaknesses and flaws that generate shame's pain. Shame erodes self-experience but is directly implicated in events which occur in the social world (Morrison 1998: x). Moreover, feelings of shame tend to occur as a direct response to the breaching of regulatory codes, whether clearly articulated or merely implied, which are formulated in the social domain. In experiencing shame the self accepts the evaluation of itself by a viewing other and is compelled to accept that the viewing other has an opinion of the self which is at odds with the one held by the self (Nathanson 1987:5). Nathanson (1987) speculates that an inherent function of shame may be to monitor interpersonal interaction. This observation parallels the conceptualisation of shame proposed by Elias (1978).

At the level of bodily expression, shame occupies the shady territory of visual regulation where what is concealed and revealed as representative of the self is assiduously monitored and managed in response to wider, socially accepted rules and preferences which the self has incorporated as its own. Linguistically the words "hide," "skin" and "shame" share core meanings. Nathanson (1987) observes "hiding" is intrinsic to the original meaning of shame. Shame, he posits, is derived from the Indo-European words *skam* or *skem* 'which means "to

hide,” and from which also derive our words *skin*, and *hide*, the latter in both of its meanings: the hide which covers us naturally, and that within which we seek cover.’ He goes on to suggest that we ‘learn to hide first for the sake of shame, and later for protection from physical danger’ (Nathanson 1987:8). As Morrison (1998: x) notes ‘it is the social aspect of shame that leads to the wish to hide, to conceal those weaknesses that generate shame’s pain’ because ‘shame is at its core about self experience.’

Those who have made shame a central focus of their study claim that shame is a particularly difficult phenomenon to access (Lynd 1958, Scheff 1988, 1990, 2000, 2003; Morrison 1998). They agree that shame is experienced at the level of the self but speculate that, because it is frequently hidden, confronting the dynamic of the way shame is played out in wider social settings also requires an acknowledgment of personal flaws and failings. Our collective reticence to confront the ways in which we may have failed as social subjects has consequences, the most significant of which is the concealing of other relevant factors pertaining to shame. Our collective aversion to confronting shame obscures how shame informs the shaping of wider cultural prescriptions and, in turn, the way these prescriptions inform self-experience. Experiential shame upholds the boundaries of social and moral acceptability while less definable shame structures delineate them. Furthermore, the ubiquity of these structures and their general acceptability are such that it is presumed that when lines are crossed, they are crossed knowingly. This in turn advances the privatisation of shame, which contributes inevitably to the detachment of shame from wider social structures that seminally engender it and allow it to proliferate in the intimate realm of self experience.

At the level of the individual, shame is endured as an intensely personal and private experience where the self feels devalued, unworthy and unlovable (Morrison 1998), whether literally or imaginatively, both from its own vantage point and in the eyes of those with whom the social world is shared. The shame experience is marked by feelings of anxiety or depression; or alternatively, anger, contempt, denial and superiority. Morrison (1998:10) suggests that these latter manifestations may deflect and mask underlying shame and divert attention from what may, in fact, be shame. Shame is a boundary concept which eclipses, interfaces and mediates personal experience and public life. To again refer to Morrison

(1989:187), shame both shapes individual psychology and plays a major role in socialisation processes, social interaction and wider sociological phenomena.

Central to the notion of shame is the experience of the self as defective, flawed or failing in some way. Through reflexive processes of self-evaluation the self concludes that it has fallen short of others', and now its own, expectations. Silvan Tomkins (1963:118) writes 'shame is the affect of indignity, of defeat, of transgression and alienation.' With somewhat startling eloquence he writes:

Though terror speaks to life and death and distress makes the world a vale of tears, yet shame strikes deepest in the heart of man. While terror and distress hurt, they are wounds inflicted from the outside ... but shame is felt as an inner torment, a sickness of the soul. It does not matter whether the humiliated one has been shamed by derisive laughter or he mocks himself. In either event he feels himself naked, defeated, alienated, lacking in dignity or worth (Tomkins 118:1963).

Body shame

It would appear that subjectively experienced stigma or shame relating to the body has become visible to social scientists only recently. In a book edited by psychologists Gilbert and Miles (2002) dedicated to researching, theorising and developing treatments for shame associated with the body, Gilbert (2003:3) writes that 'body shame' is a 'relatively new concept' which is yet to be clearly defined and properly understood. Preliminary formulations note the close link between shame and social anxiety where poor self-evaluation and stigma awareness lead to poor self-ideation. The stigma awareness associated with appearance articulated by those who took part in this study deviated little from Cooley's (1964) original formulation, confirming that participants had an acute understanding that physical appearances are actively, and continually, being evaluated and accorded value by themselves and others. This unremitting evaluation was understood to occur within judgemental and potentially punitive social frameworks where participants believed that they, along with women more generally, would be included or excluded from participation in social life based on the relative acceptability of their physical appearance. Participants believed that their appearance affected their actual and potential life chances. This was

evidenced in the recurrent citation of activities ranging from the mundane, like not being served in a shop or restaurant, to more crucial events, like being overlooked for a job, which participants attributed to their physical appearance.

Many single participants offered an appraisal of their pre-surgical appearance in which they saw themselves as being so undesirable that they were unworthy of the love of another. Cooley (1927) might have suggested they viewed their appearance as a significant determinant as to whether they were in or out of 'the game;' or perhaps more precisely here, included or excluded from the libidinal economy. The metaphor of being in 'the game' is invoked by a cosmetic surgeon interviewed by Blum in her study of cosmetic surgery in America. Commenting on the liposuction he has just performed on a seventy year old woman, the surgeon opines 'When you're seventy and you think you've got another thirty, forty years, you don't want to sit on the porch and rot. You want to stay in the game' (cited in Blum 2003:270). 'The game' also carries connotations of the social world as mapped and marked by abstract borders demarcating inner and outer zones, where ageing carries with it meanings associated with deterioration and waste. As my interviewees repeated across the interviews, these structures, abstract as they are, are nonetheless acutely felt.

Gilbert (2002) does not acknowledge Cooley (1964) but his conceptualisation of body shame nonetheless reiterates the extremes of pride and shame which Cooley (1964) proposed that the 'looking glass self' mobilises in self-evaluation. Pride and shame are emotions of self-assessment and these assessments are undertaken continuously and adjusted in response to changing social contexts where the perceived evaluations made by others are internalised. While participants in this study rarely used the term 'shame' to describe how they felt about their body image, and sought cosmetic surgery rather than psychological therapy to resolve a disliked body image, oppressive themes of disgust, revulsion, embarrassment and loathing were consistently used to describe pre-surgical appearances. However, it is the impact of flawed body image on self-conceptualisation which suggests that shame may be a determining factor in shaping the motivations of those who seek cosmetic surgery.

Karen

For some participants the feeling of abhorrence surrounding body image was so extreme that viewing themselves in the mirror had been assiduously avoided. Being able to confront their reflection only became possible when the decision to proceed with surgery had been considered and the potential solution necessitated planning to ameliorate the problem.

Karen's account provides an example. Karen described her weight as 'ballooning' in the aftermath of a distressing and 'untidy' marriage breakup. She came to dislike her appearance intensely and said that 'there was no way I would stand in front of a mirror unless I really had to' (Karen). Needing to distance herself from her estranged husband, Karen and her two children moved to another city to be nearer to her supportive family. Karen's decision to lose weight followed an acute medical event which had threatened her mother's life and brought her own mortality into heightened focus. This event was crucial to Karen in underlining her parental responsibility to be healthy enough to care for her own children. It is worth noting here that Karen's mother sustained an adverse drug reaction while undergoing an abdominoplasty, surgery which Karen carefully differentiated from her own as necessary to alleviate her mother's back pain: her mother's surgery was to improve a medical condition whereas hers was to improve the aesthetics of her appearance by the removal of excess skin following her dramatic loss of weight.

This was one of many instances observed in this study where cosmetic surgery, for either elective or medical reasons, had been undertaken by a relative or close friend of a participant. Participants regularly acknowledged that knowing another person who had undertaken cosmetic surgery had the effect of normalising it as something they could then consider for themselves. One participant spoke of her aunt's cosmetic surgery as 'blazing the trail' for her own subsequent surgery. Participants spoke of friends, mothers or sisters who preceded them in having cosmetic surgery. They also spoke of actively encouraging their own friends to have the surgeries which had been successful for them. Such observations suggest further possibilities in the dynamic of shame associated with body image: firstly, that body image shame is shared and acknowledged within groups of women who are close friends, and secondly, that the anxiety about body image from which this type of shame becomes manifest may well be transferred from generation to generation of mothers and their

daughters. This last point reinforces an observation made by Elias (1978) in the previous chapter, which suggested that shame is reproduced and reiterated in intergenerational socialisation.

By her own account, Karen had a long and unsuccessful history of dieting extending back to when she was a teenager. She recalled that it “did her head in” when her mother invited her to talk about how *they* were going to manage *her* weight while offering her cake to eat. Following her separation from her husband, subsequent weight gain, and numerous failed dieting regimes, Karen underwent the surgical weight loss procedure laparoscopic banding. Having her appetite radically curbed provided Karen with a legitimate reason to resist her mother’s efforts to feed her. In the four years following her surgery Karen lost sixty-five kilograms. However, in an incongruous twist, rather than being happy with her weight loss Karen began to find her appearance even more grotesque than she had when she was overweight. Here she explains:

I think (she pauses) ... by the time you get to the point where you’ve lost that much weight that you have that much extra skin, you sort of think, “Well, what was the point of that? In a way I look worse now than I did when I was big,” because it just looks so unnatural to see that. The surgery certainly has helped with my own personal body image, just to get rid of some of that hanging skin and just for my body to be more functional really. Just being able to do more and more things, without having to worry about getting rashes or being embarrassed by all that skin floating around (Karen).

Her redundant ‘hanging skin’ no longer served any purpose; it had become a hindrance, a site of potential contagion and literally ‘matter out of place’ (Douglas 1966). At the time of interview Karen had twice had extensive cosmetic surgery. The first removed excess skin from her breasts and abdomen, and the second from beneath her upper arms. She had subsequently lost more weight and the hanging effect of loose skin had recurred. Consequently, she was less happy with the aesthetic result than she had been and was considering further surgical review to those areas. She also planned more surgery to remove superfluous skin from her thighs. Karen was one of three participants in this study who had undergone a surgical weight loss procedure and subsequently undertook, or planned,

cosmetic surgery to follow up extreme weight loss. Statistics from the ASPS (2004) highlight an American trend where weight loss surgery is driving an increased demand in cosmetic surgery to remove the excess skin which the rapid and dramatic weight loss, apparently characteristic in these types of surgeries, causes, thus emphasising a modern, thoroughly medical solution to the so-called obesity epidemic.

Prior to weight loss surgery Karen felt that she had exhausted her weight loss options and urgently needed to get some order in her life. She had worked in hospitality but was finding it difficult to get work in a new town. Moreover, she felt so embarrassed by her appearance that she was unable consider a new relationship and any exposure of her body which that might entail. As the sense of her own abjection mounted she began increasingly to see her own mortality as threatened. Karen recalled thinking, 'I'm just going to eat myself to death if I don't do something about this.' It became increasingly obvious that she was being excluded from social life because of the unacceptability of her appearance and she needed to take action to ameliorate the situation. At around the same time she had weight loss surgery Karen enrolled at university and subsequently completed an undergraduate degree. In keeping with the way in which psychoanalysts have implicated the notion of 'hiding' (Nathanson 1987) as a characteristic associated with shame, Karen described this as a period when she dropped out of the 'real world;' as a pause in her life when she lost weight and re-educated herself. Her experience parallels that of a number of women in this study for whom cosmetic surgery was but one of a repertoire of transformative changes enacted to institute a more positive self-image. Such a repertoire typically involved re-education or reskilling, relocating and establishing new social networks. For these women rehabilitating the shamed self typically involved a multifarious approach which rarely relied upon the reparation of body image alone. When I asked Karen if she felt that she had ever been knocked back for a job because of her size she replied:

Karen: Yes. It got to a point where I just thought, "There is no point in looking for work." Then I came to the decision where I thought, "Well, OK, this has to change and I need to re-educate myself to work in something else." While I was studying I saw it more as a respite from trying to look for work while I got myself organised, as an opportunity, to not just sit and do nothing

but re-educate myself at the same time. So I managed to roll it all into one and have three years study while I lost some weight before going back out into the real world, so to speak.

Jane: It sounds like you withdrew ...

Karen: Oh definitely (Karen interjected quickly). Just prior to having the lap band and deciding to actually do something serious about it, I was very, almost, you know, I would cut my hair in a way that made me look worse, and it was almost like I was doing it to myself, to make myself look as bad as I possibly could look, so I would wake up and realise I needed to do something.

Karen exposed her inner psychodrama where the divisive play of her inner selves took a leading and crucial role in addressing her conflicted body image. One, the parental voice of reason, is desperate to convince the other, disordered, chaotic and childlike, that her life, through her body, needs to be recovered, organised and brought to order. Or, as she articulates below and elsewhere in her interview, she risked exclusion from work and intimate relationships, while being scorned as an obese woman.

You know, I could walk into a shop and I would be invisible, whereas now when I walk into a shop, more often than not they will ask if I want any help. Just that kind of thing. People tend to talk to you a lot more and not see you as a person with a disability that should be hiding in a corner ... Even going out to a restaurant as a really big person, you just feel that you shouldn't be eating. It might be the only meal you have eaten that day, but people look at you as if to say: "Well god, haven't you had enough to eat" (mimicking a reprimand)?' (Karen).

From her inner selves to the intrusive eyes of disapproving and judgemental others, Karen felt that she was evaluated as unacceptable. Her experiences were not unique or remarkable. They concur with a litany of similar experiences repeated throughout the accounts of the bigger participants. Bigger women whom I encountered socially while doing this research echoed Karen's experience of feeling judged when they ate in public. One acquaintance who had also lost weight following laparoscopic banding said, with a sense of sadness, that one of the most wonderful things about losing weight was being able to enjoy eating an ice-cream while she watched her kids at the swimming pool without anyone glaring at her and making her feel ashamed to be eating. Extensive quotes from participants cited in the sociologist Marcia Millman's (1980) qualitative study of fat women in America repeat the felt shame

which big women understand their bodies to publicly symbolise. For Millman's interviewees too eating in public brought an amplified sense of shame, a sense that those who witnessed them buying or eating food judged them with contempt. Moreover, this felt contempt frequently saw them returning home with their purchased food to gorge in private, hidden away from public scrutiny. As Morrison (1998:8) observes, 'shame begets shame,' and for Millman's participants being exposed to the glare of public humiliation led to withdrawal and a proliferation of behaviour that brought with it more shame. Although Millman is both empathetic and generous in presenting her participants' accounts, it is nonetheless disappointing, given that themes of shame were repeated so frequently and unambiguously, that she does not build upon nor develop a more complex theoretical explanation of the shame-like experiences her participants so clearly describe.

It is enlightening to reflect upon the language Karen chooses to describe the interface of her bigger body with the social world: 'invisible,' 'disability' and 'hiding in a corner.' These terms are in line with theoretical formulations of shame, but she herself was reluctant to use the term. Rather, she nominated her flawed self as failing to enact self-control, which is conceptually closer to the theoretical framing which Elias (1978) gives shame. For Karen it was clearly preferable to say she was lacking self-control than to say she experienced shame being a bigger woman. When I suggested that there might be shame associated with being bigger, her response was clipped and dismissive. My question was explorative, as any understanding of the relationship between shame, body image and cosmetic surgery was developed during the course of the project and only became evident as analysis of the interviews and subsequent reading proceeded. However, shame is particularly difficult to access. It is both confronting and painful. Karen equated shame to a notion of weakness and promptly distanced herself from the term. In doing so she highlighted the inherent difficulty we all share in associating ourselves or our actions with notions of shame:

Jane: Do you think there may be some shame associated with being bigger?

Karen: Oh, I've always been a fairly strong person, and had fairly strong convictions, so I don't think it was shame. It was more lack of self-worth or lack of self-control, or disappointment in myself at not being able to control the situation. We don't often open up and show all our

insecurities to the world, but when you are that large, that is your insecurity, and there is no hiding it (said brusquely).

By adopting the collective 'we' to speak about herself, Karen momentarily distances herself from herself to take the view of the other in observing herself. This allows her to sidestep the smarting jab of pain that my question inadvertently evoked. Lewis would describe this as a "“distancing” manoeuvre” which facilitates the ‘by-passing’ of shame (1971:38). For Lewis (1971:38), a defensive mechanism like this ‘does not obliterate the recognition of shame events, but appears to prevent the development of shame feeling.’ Karen is not alone in her reticence to associate herself with shame. Social scientists too have difficulty grappling with the idea, despite the fact that social exclusion, social rejection and what, in many cases, might be considered the outcomes of experiencing shame have long been the foundation upon which the discipline has been built. Antithetical to the notion that the ‘social self’ demands positive social interaction, as James (1950) suggests, is the countering dread of fear and anxiety associated with the threat of social exclusion and rejection. Prominent thinkers from Freud (1936), and his claim that the fear of separation is central to all anxiety, through Durkheim’s (1970) study of the relationship between suicide and anomie, to contemporary scholars such as Bauman (2004), credence is given to the importance of social inclusion in directing individual behaviour and the patterned outcomes of social life. However Elias (1978), Lynd (1958) and Scheff (1988, 1990, 2000, 2003) are just a notable few from the discipline of sociology to make shame a central focus of their study. They identify shame as the medium through which subjective experience is explored on the fault lines of social life where collective notions of social acceptability pervade self-perception when negotiating the elusive structures which enable participation in privileged social domains.

Themes emanating from this study highlight the participants’ awareness of stigma regarding appearance. Such awareness had impacted upon self-appraisal which left some in fear of bodily exposure and, in turn, lacking the self-confidence to pursue intimate relationships and, for a smaller group, the eschewing of active participation in social life until their appearance had been surgically amended. Participants like Karen viewed their excessive corpulence as an unavoidable public display which signified they were out of control. Her reflections are in

keeping with themes of shame proposed by Elias (1978), which highlight the failure of self-mastery over the body and the subsequent social exclusion that will almost inevitably ensue. However, there are other aspects of Karen's account which relate to the way she came to perceive her body image as anomalous to which I wish to draw attention. Karen's problem with her body image had a long history stretching back to when she was a teenager. Karen's mother also had issues with her own body image, even though they had been conceptualised as medical, she nonetheless sought a surgical resolution to an anomalous bodily feature. The timing of Karen's decision to embark on a surgical process to resolve her body image is significant. It followed a relationship breakup and a re-evaluation of the way she was going to negotiate the next stage of her life. Her process of self-evaluation was informed and reinforced by others, including strangers, whose keenly felt judgements confirmed her appearance as unacceptable. In addition, her conflicted psychodrama of inner selves resonates with the processes which psychoanalysts describe as implicated in the shame dynamic and how it comes to be instated in self-perception. Karen's account was chosen because of her clear articulation of these processes, but hers is only one example of many similar accounts repeated across the interviews. Such thematic persistence of shame-related experience points to a complex relationship between women, body image and self-perception, and also suggests that those who seek out and undertake cosmetic surgery may do so as a way of resolving deeply felt personal shame which is expressed through the embarrassment and abhorrence that they believe their pre-surgical body image elicits. In the post-surgical phase, themes suggestive of shame are evidenced when the changes initiated by cosmetic surgery are positioned conceptually within the transformative continuum of shame to pride. As one woman said after her breast reduction:

I just feel that I have more confidence in myself, more pride in myself ... That I'm not as self-conscious as I use to be ... Yes, to be able to get out of the shower and stand in front of the mirror and think, "I now like how I look and I'm not trying to hide myself away anymore" (Liz).

Karen also located her experience with cosmetic surgery along the transformative trajectory of shame to pride. She envisaged many more surgeries ahead as she was yet to reach her goal weight and the more weight she lost, the more her shrunken body would become

encased in folds of redundant skin. When I asked whether the scarring from subsequent surgeries would ever be an issue for her, she rejected the suggestion:

No, not really ... I'm not going to stop here. I want to go all the way. I owe it to myself, really, to make sure that I end up one hundred percent happy. And as far as the scarring goes, that's just a mark of success for me; a reminder of what was once there and is not any more (Karen).

Karen's response surprised me. Surgery always leaves evidence of its enactment but because cosmetic surgery is elective and usually affects uncompromised skin the potential to minimise scarring is optimal. An enhanced appearance without evidence of surgical involvement is a highly desirable aesthetic goal of cosmetic surgery and integral to notions of authenticity and passing (Gilman 1999) which underscore cosmetic surgery's mandate. For Karen, scarring will be extensive and never completely invisible. Covino (2004:36) suggests that because cosmetic surgery is elective, the subsequent scarring can also be considered self-inflicted, and 'mark the point where visible and abject body once existed.' Rather than trying to hide her scars, Karen embraced them as symbols of her struggle with her weight. They invoke remembrance, triumph, and, indeed pride in the form of inscriptive scarification.

Modern medicine readily demonstrates the tendency to define the body as a contested entity; a battle ground in which notions of selfhood and embodiment have been reclaimed from the enchantments of pre-Enlightenment fantasy. It has classified the body into various zones and overlain it with mechanistic metaphor that further encourages a fragmentation and disconnectedness between body and self. Like the military metaphor used in 'battling cancer' (Sontag 1991), the "fight" against obesity too is shifting to centre stage as the newest plague in the medically mediated expression of contemporary embodiment. Participants for whom weight had been a lifelong issue reiterated the imagery of "battling weight." On this emerging front-line internalised shame may yet prove to be the most effective weapon, but the heavy-handed approach used in conveying public health messages about obesity will not be without consequences. Shame is both subtle and powerful in engendering anxiety and heightening vulnerability at the level of the individual. In Australia, the increasing number of anorexic children being admitted to paediatric units, who are both younger and in

perilously compromised health on admission, has been noted with considerable alarm (Scott 2008). Such research adds to mounting evidence which suggests balancing the imperative of public awareness of the dangers of obesity with the need to promote a positive body image across a variety of body shapes and sizes is a public health challenge in its own right. This study found resounding evidence to suggest the legacy of poor body image development in childhood and adolescence can have effects persisting well into adulthood.

Unveiling shame

As this study progressed it became increasingly clear that shame is implicated in poor body image and that the susceptibility to spiral into shame had, in many instances, begun in early childhood or adolescence. I became increasingly interested in understanding how shame had been explained and conceptualised within academic literature. In the process of researching shame I was directed by Scheff's (1988, 2003) sociological account to an apparently obscure but impressive book, *Shame and Guilt in Neurosis* by Helen Block Lewis (1971). Lewis was a research psychologist and practicing psychoanalyst working and writing in the mid-twentieth century in America. She was compelled to write her book to explain the failure of therapy in a small but nonetheless disturbing group of her patients. Lewis began to notice patients re-presenting for treatment a few years after what had been deemed successful treatment in a worse psychic condition than they had originally been in. While a central goal of psychoanalysis is to encourage self-acceptance and develop resilience to situations which make self-acceptance difficult, Lewis found a small group returning for therapy even more self-critical than they had initially been. Characteristically, these patients had adopted a psychoanalytical vocabulary and manipulated the insights which they had gained in the initial therapy sessions to further derogate themselves. Not only were her own ex-patients re-presenting for treatment but she began to see a growing number of other patients for whom psychoanalysis had failed to provide long term success. Lewis noted a recurrent theme put forward by patients themselves which posited unresolved traumatic childhood events as diagnostically causative to ongoing and tenacious 'hang-ups ... permanently malforming their characters' (1971:13). She felt that something significant was seriously amiss in the theoretical and therapeutic approaches within psychoanalysis, and her study sought to uncover any relationship between difficult life experience and previously obscured links with

the manifestation of shame and guilt. Although Lewis' study focuses on shame as pathology, her insights are nonetheless valuable because of the detail of her study and what she was able to reveal about the way in which shame functions and is replicated in day-to-day life.

Furthermore, Lewis' insists that shame and guilt are the outcomes of a complex interweaving of social and psychic experience, rather than contained intra-psychic phenomena, which makes her study particularly amenable to cross-disciplinary application.

While it appears that shame may often be closely implicated in matters relating to sex and the body, history has shown shame to be far from a sexy topic of research. Studies dedicated to exploring shame have generated only marginal interest from within the social sciences, and this may be because shame is, as has been said, a particularly difficult subject to access for researchers and participants alike. Lynd (1958:67) suggests that it is not just the fear of isolation and alienation which shame elicits, but the shame experience itself that is 'isolating, alienating and incommunicable.' Shame resides in the darkest recesses of reflexive and psychosocial experience and when shame is registered by the self it is experienced as deeply personal and private. Keeping shame hidden is a feature of its occurrence. However, while shame might be felt as a deeply personal experience, it is not an inherently human attribute; rather, it occurs as an outcome of social interaction. Will's (1987) definition of shame is worth repeating here for his explicit enunciation of the relationship between private experience and public rule embedded within the shame dynamic:

Shame is a painful, unpleasant emotion experienced as an accompaniment of some awareness of wrong-doing, impropriety, shortcoming or transgression of behaviour and concepts of what is held to be "right," "good," or acceptable within a particular group. It is equated with feelings of disgrace, dishonor, infamy, humiliation, odium, or the like, and may be accompanied by physical sensations of apprehension, disgust, nausea, and dread. To be ashamed is to be faced with censure and the possible withdrawal of the human support that is felt as necessary to exist with some semblance of comfort ... The most severe penalty for rule violation is the threat of being cast out or abandoned, that is, being exposed to a form of social, and sometimes physical death (Will 1987:309,310).

An extreme example of shame is found in the practice of honour killing, still prevalent in some parts of the world which is most frequently ordered by familial elders upon a young female relative who has liaised with a man of whom they do not approve. Shame, embodied in the young woman, is eradicated to restore honour to the family. Homicide becomes both ritualised cleansing and restitutive action. Like contagion, shame has curious properties: it disrespects boundaries and leaks its tainting effects. One may be shamed by implication and association, by the exposure of shameful acts committed by significant others, family members, workmates and, indeed, political leaders. Regardless of when and where it occurs shame is hushed and hidden and the restitution of the veneer of normalcy and order is relentlessly sought.

The rules surrounding shame specific to any given social group map out and define how one may embody and physically inhabit their social world. Parents actively engage in shaming their offspring in the earliest socialisation around bodily control, invariably influencing self and body image while reinforcing social meanings surrounding the body (Morrison 1989:187). As Lewis (1971) and others (Scheff 1988, 1990, 2000, 2003 in particular) have observed, shame underpins and defines our personal experience and shapes how we interface with the social world; yet, in a puzzling twist, we turn away from acknowledging shame and, as a result, we are directed away from discussing the pervasive and ubiquitous nature of its dynamic and the way in which it functions in regulating and informing social life. Lewis (1971:17) remarked that the phenomena of shame had received scant attention by psychoanalysts, and, according to Scheff (2003:259), Lewis' work was generally eschewed and did little to alter the situation. Scheff (2003) suggests that, because the properties of shame are so pervasive, social scientists themselves shy away from subjecting it to any scrutiny. Referring to America, he cites Kaufman to reiterate: 'American is a shame-based culture' yet shame remains hidden, subsumed as taboo; moreover, the taboo on shame is 'so strict *we behave as if shame does not exist*' (Scheff 2003:240, his emphasis).

Linguistically shame takes on what it represents symbolically, and in the process the emotional dimensions of shame are prohibited and consequently denied. People are ashamed to talk about shame and, as a result, the way in which shame operates as a determinant of social control is largely obscured and hidden from view (Scheff 2003). Unfortunately this

means that any exploration of shame may have inherent limitations which relate more to the aversion which society generally feels in acknowledging its properties and less to do with the way in which it has been conceptualised.

Shame and guilt are frequently conflated, or shame is posited as the precursor to guilt. Although Lewis (1971) agrees that their meanings may shift, merge and blur, she delineates shame and guilt as two distinct experiences and differentiates them in their relatedness to the reflexive dialogue between self and an internalised other. Guided by Freud, William James and developing upon her previous work, Lewis (1971:18) utilises three constructs: the Freudian 'superego,' James' formulation of 'the self' and her own work on 'psychological differentiation' to create a theoretical frame through which to explore shame and guilt.

Freudian socialisation

As has been noted in this study, poor evaluation of body image was thematically significant in the pre-surgical assessment of the self. According to Lewis (1971), poor self-evaluation is centrally important to the experience of shame, and she explains self-monitoring evaluative processes through the Freudian model of socialisation. An outcome of integrating the superego is the regulatory capacity to monitor and self-evaluate behaviour. Guilt, pride and shame are outcomes of this self-initiated regulatory process. The values and morals which guide this monitoring agency are framed by significant others or the superego construct (Lewis 1971:19, 20). We saw in Karen's inner tussle of competing selves how this monitoring function might present. The superego construct which Freud formulated (see *The Ego and the Id*) attempted to explain the distinct phenomena intrinsic to the socialisation process. Elliott (1992:39) reminds us of the 'breathtaking problem with which Freud was grappling' in his quest to explain how small children come to acquire the social code of their society. Through the superego Freud attempted to understand the way in which instinctual behaviour, or the drives, came to be regulated. He sought to explain how wider social values and ideals are taken up within the oedipal relationship of the family.

The way in which these processes of introjection, or the internalisation and acceptance of parental attitudes represented in the superego function, and the way in which small children

subsequently identify with the aforementioned values and rules requires further elaboration. Freud hypothesised that the superego was incorporated through the phenomenon of identification. By identifying with parents and significant others children adopt parental attitudes and values to become like them. In her reading of Freud, Lewis (1971) identifies two routes by which the process of identification occurs. The first relates to the introjection of the castration threat, the second to the imitation and emulation of admired and significant others. The castration threat, or more broadly the fear of rejection, is internalised by the small child when caregivers attach punitive consequences to actions deemed to be “wrong,” and these regulatory practices are subsequently taken in and incorporated as the child’s own. Thus small children come to understand that breaching parental authority potentially carries with it the consequence of rejection. States of love, rejection and acceptance may be interpreted as highly conditional. In effect, castration can be understood, both metaphorically and symbolically, as the exclusion from social life resulting from a breach of social rules. Elliott (1992:40) contends that the castration threat is, at its source, the basis of all cultural prohibition and social taboo.

Within the oedipal setting proposed by Freud the castration threat is the perceived action of the father symbolically intervening to break the dyadic relationship between mother and infant (Elliott 1992). Here it is the denial of infant access to the maternal body through feeding that the father is understood to prohibit. Up until this paternal intervention the infant considers its body to be continuous with its mother’s. Recognition that the father intervenes in order to reclaim possession of the maternal body may once again be symbolic but, in Freud’s view, it acts to repress the incestuous desires of the child for the maternal body and launches the child as a separate entity in the social world. According to Elliott (1992:38), Freud, through the castration complex, elaborates the essential condition of the psyche’s entry into society; the establishment of the symbolic order and the way received social meanings and practices underline what is allowed and what is forbidden. Paternal law prohibits the child’s libidinal desires towards its mother’s body and the subject is accordingly introduced to wider familial and social structures from which it will always remain, in a sense, “excluded.” This exclusion is the very meaning of the castration complex. Moreover, fear of exclusion underpins the anxiety characteristic of the shame experience and it is

generally agreed to be centrally implicated in the phenomenon of shame (Elias 1978; Scheff 1988, 1990, 2000, 2003; Lewis 1971, 1987a; Morrison 1989, 1998; Will 1987).

The second route by which the superego construct is introjected occurs through processes of imitation and emulation where the child structures its activities in line with an admired adult imago, parental figure or ego-ideal. Lewis (1971:21) notes that 'Ego-ideals may develop in connection with such diverse activities as moral behaviour and sexual attractiveness.'

Furthermore, failure to live up to an ego-ideal carries the potential threat of losing parental love. Here the 'loss of parental love becomes loss of "self-love," via loss of esteem in their eyes' (Lewis 1971:21). In other words, losing the admiration of significant others can result in the loss of self-love or self-esteem. This is an important observation for this study since just over half the participants felt that they had struggled with body image for much of their lives and understood their negative feelings to have a long history reaching back into early childhood experience when formative impressions of self and body image drew heavily on interfamilial interaction. This last point is one which I will elaborate below when examining participant accounts in further detail. For now it is important to note both Lewis' (1971) and Elliott's (1992) examination of the introjection of the superego emphasise how admiration, emulation and fear of rejection underpin the socialisation process and frame the terms under which cultural and social rules are internalised.

Lewis (1971) makes a fine distinction in the route by which internalisation of the superego occurs in determining the potential outcomes of guilt, pride and shame. She contests previous formulations which locate shame in a sequential order as the developmental precursor to guilt. In Lewis' view parental threat and the subsequent internalised threat characteristic of the castration complex are more closely related to breaches within a given parental value system and any contraventions of that system are more closely associated with guilt. This is in line with the classical Freudian model of the castration complex which argues that concomitant with the repression of his desire for the maternal body the male child feels guilt. In the case of guilt, Lewis suggests that it is the violation of an event or a rule that is problematic, rather than the actual self. In guilt it is the *actions* of the self that are brought into focus, unlike shame, where it is the actual *self* that is subject to negative

evaluation. Lewis is at pains to emphasise that the failure to live up to the internalised imago, the second route available to internalising the superego noted above, and the ensuing negative evaluation of the self which emerges from that failure is constitutive of shame. She contends that shame, as has been suggested by a number of authors (Cooley 1964, Taylor 1985), emerges from the process of self-evaluation and she offers a plausible proposal for how this might occur. Lewis agrees that both guilt and shame emerge within the heuristic function of the superego, but she is explicit in her distinction as to how these ‘feeling states’ emerge:

Specifically, identification with the threatening parent stirs an “internalized threat” which is experienced as guilt. Identification with the beloved or admired ego-ideal stirs pride and triumphant feelings; [however] failure to live up to this internalized admired imago stirs shame (Lewis 1971:23).

This last point is important as many participants clearly loved their parents and could see that their actions had informed their subsequent feelings of poor body image, but they resisted blaming them for this occurrence. Shame occurs in the vulnerable context of wanting to please beloved significant others but fearing you have failed, not only in their eyes but your own. Central to Lewis’ conceptualisation of shame is the relationship of the self to the internalised other; the way in which the self is directed by the internalised, imaginary other, and the inherent vicariousness such a relationship reveals.

In guilt, the value system ... is likely to be the focal point of the person’s awareness, rather than an awareness of himself in relationship to the internalized “other.” In shame, the internalized admired imago functions more visibly as the referent “in whose eyes” shame is experienced; a “shadow” of the imago falls on the self. This internal theatre of shame may be played out in the feeling of shame and humiliation before the “other,” or it might be played out in ideation. In the latter case, the person does not experience the full effect of shame, but rather has thoughts about what the “other” is thinking about the self. These “watching” thoughts may include the awareness that the person is thinking about what the other person is thinking about him. In this kind of instance, the self is both participant and watcher in its own fantasy ... Shame functions as a sharp, in fact painful reminder that the fantasy experience of the “other” is vicarious.

Shame brings into focal awareness both the self and the “other,” with the imagery that the “other” rejects the self. It thus helps maintain the sense of separate identity, by making the self the focus of experience (Lewis 1971: 23-25).

Lewis’ (1971: 24) suggests that ‘watching’ thoughts are as Cooley (1927) implies, related to erotic imaginings, but she goes further to suggest that when the evaluative process evokes shame it will then function to protect the self against the loss of its boundaries. However ‘watching’ thoughts, while sometimes erotic, are always evaluative and affect individuals in meaningful ways. Lewis’ ‘internal theatre of shame’ resonates with the rehearsal described by participants in this study who evaluated themselves in the mirror and re-imagined themselves when surgically enhanced as a way of circumventing or ameliorating shame by protecting their own boundaries. Lewis’ formulation of the ‘internalised other’ also brings to mind Cooley’s (1964) ‘looking glass self’ discussed in a previous chapter. Although Cooley grabs our attention by exposing everyday ritual with disarming familiarity, he fails to elaborate on the way feeling shamed by an imagined critical other can impact upon the self. However, he does, to be fair, acknowledge the serious consequences of privately established negative self-evaluation and recognise that the outcome of such an evaluation, whether real or imagined, carries the potential risk of social marginalisation, or, to stay with Freudian terminology, castration. The fear of rejection, whether real or imagined, underpins the shame experience.

Lewis’ (1971) notes several properties as being integral to the self. Firstly, she defines the self as ‘the experiential registration of the person’s activities as its own,’ adding this registration of activity may occur both consciously and unconsciously (Lewis 1971:32). Shame results in a state of heightened self-consciousness as it is the occurrence of shame which brings negative self-evaluation into direct focus. The second property of the self which is significant to shame relates to the bounded notion of the self. As was previously suggested, the vicariousness of experiencing the self through the eyes of the other highlights the permeability of the self. Heightened emotional states like being in love and experiencing shame underscore the permeability of the self-boundaries. For example, we may feel ashamed by association or by the actions of those close to us. Being sensitive to the beliefs

and values of the other highlights the permeability of the body/self boundary. Those who have 'permeable' or 'soft self-boundaries' are also those who are the most vulnerable to shame (Lewis 1971:31, 204). Implicit to the notion of the bounded self is the literal spatial localisation of the self within the body. The self organises itself within the social field through the sensory capacities of the body. Perceptions through embodied sensory modalities enable and facilitate experience and interaction within the social field. However, interpreting and making sense of what one perceives is impacted by social variables like gender, class and race.

For Freud, shame was left behind in the realm of childhood socialisation and guilt was posited as the more significant affect relevant to adult experience. He described shame as a particularly feminine experience, 'a female characteristic par excellence' of the young girl inevitably shamed by her flawed body, inferior anatomy and already castrated status (Lewis 1987a:31). Contentiously, Freud claimed that the very hidden nature of female genitalia, in comparison to the masculine phallus, further compounded the lack of clarity she felt in formulating her body image which resulted in a 'permanent sense ... of narcissistic injury or shame' (Lewis 1971:146, 7). Lewis (1971:147) and her colleagues did find that women more generally have difficulty differentiating themselves from their surrounds, and Lewis herself suggests that this lack of clarity in formulating body image has further implications in the formulation of self-image. She contends that women experience their sense of body image as less clearly defined, which in turn fosters an unclear 'separation of self and other images, and a greater proneness to shame' (Lewis 1971:147). Her ideas linking social structure, gender and the vulnerability to shame are elaborated upon through the concept of psychological differentiation.

Psychological differentiation

Through the concept of 'psychological differentiation' Lewis (1971) argues that being dependant or independent within the social field may predict an individual's vulnerability to shame. Lewis and her colleagues initially deployed psychological testing under laboratory conditions to argue that individuals' perceptual and physiological capacities to orientate themselves in a series of unfamiliar environments varied. Additional testing sought to assess

the capacity of the self to differentiate itself from its surroundings. From the results of these tests Lewis et al. (Lewis 1971) identified one group as more easily able to orientate itself independently of its environment. This group was also able to separate itself from its surroundings. Lewis et al. termed this group 'field independent.' The second group demonstrated an increased reliance on their surroundings to orientate themselves and had difficulty separating themselves from their surroundings. Conversely, this group were described as 'field dependent.' To confirm any social implication which might be inferred from their findings, Lewis and her colleagues turned to cross-cultural studies and socialisation styles, noting that other variables such as gender and the propensity to shame were characteristic to the group identified as field dependant. Lewis observed that women were more frequently found to be field dependant and were also found to be more vulnerable to experiencing shame.

While Lewis (1971) was clearly aware that women's experience of embodiment, shame and social life are interwoven and implicated in the shaping of emotional experience, she also noted the connection between women and their appearance. She observed that in the eyes of their fathers, middle-class women were not expected to achieve in the wider world beyond being 'pretty, affectionate, sweet and nice' and were rewarded for adopting passive social roles, whereas women who adopted more independent traits risked stigmatisation (Lewis 1971:145). Lewis goes on to speculate that the trend for women to beautify their bodies is related to their dependency on men and 'their tendency to beautify their bodies fosters their proneness to shame and vice versa' (1971:146). While it is widely understood that beautiful women may accrue a great deal of social power through their desirability to the other, Lewis is making a more salient point here by suggesting that from positions of subordination, and the inevitable dependence which that entails, women have traditionally been shamed because the evaluation of their worthiness has been, in part, related to their external appearance, and the terms defining its value have been designated by another. Here Lewis locates the experience of shame in grooming practices, gender and social structure. In addition, she contends that the prevalence of shame experienced by women was also related to the types of work they were limited to. As the labour of women was generally confined to caring roles,

Lewis argues, women were encouraged, or better, socialised, to be aware of the needs of others in ways which men of the era did not necessarily experience in their working lives.

Lewis' (1971) formulation of shame links dependency within the social field, and the reduced social power which that engenders, to the phenomenological experience of the self through a vulnerability to the thoughts, beliefs and values of the other, but she situates these experiences within wider social structures which reproduce and reinforce the dynamic of shame. From their position of dependence, children are always prone to shame. Moreover, their experience combines soft borders and formative experience. Likewise any marginalised, socially disadvantaged group will share an increased vulnerability to shame arising from inherent dependence (Morrison 1998). Following the trajectory of this logic, it can be suggested that those who are denied social power are less able to exert control over the social worlds they inhabit and, consequently, themselves. From a subordinated position, those who are marginalised have limited opportunity to shape the values, ideals and preferences of the dominant order. Shame is most frequently experienced by those who occupy positions lacking social authority, those who find themselves in social situations where the parameters of shame are determined, not by themselves, but by a more powerful other. However, because punitive regimes demarcate the shame experience, such values are frequently internalised as one's own. For women, already socially disenfranchised, shame adds uncertainty to the containment of the body's boundaries, amplifying their fragility and permeability.

In the shame experience the self splits to take on the dual function of both spectator and participant in its own experience (Lewis 1971:425). This is because the self, within the confines of the body, is disturbed by the intrusion of the other who emerges from outside the self and its bodily confines (Lewis 1971:33). In the shame experience 'the locus of significant events is experienced as "out there," or in the field, but the experience of shame requires an internalized standard of reference' (1971:115), and it is the internalisation and acceptance of the other's standard which is characteristic of the shame experience. Shame, then, as Lewis (1971) describes it, is a particular organisation of the self's relationship to itself and the social world within which it interacts. It emerges from an evaluative process

mediated reflexively and imaginatively through the eyes of an internalised, significant other to whom the self is emotionally connected; one for whom the self cares deeply about, may be dependant upon and, importantly, from whom the self is vulnerable to rejection. Shame, therefore, may be understood as a vicarious experience of the significant other's disapproval or scorn (Lewis 1971:42). To illustrate how these processes might unfold I draw upon an account given in this study.

Wendy

Wendy was forty-nine when she was interviewed. She had been married, divorced and was currently in a stable relationship. She had adult children and was employed in a job she enjoyed, working in middle management. Wendy was booked to have an abdominoplasty, or as she euphemistically described it, a "tummy tuck," three months after the date of her interview. Like others in this study Wendy had a long history of dissatisfaction with her body image reaching back to her early childhood experience. Wendy described herself as coming from a family of 'big women' and recalled how she and her three sisters were routinely reminded by their parents that 'they would end up looking as fat as their fat aunt' if they overate. Of note in Wendy's account was the way in which she evaluates her appearance by comparison to others. She compares herself to her sisters: they were more muscled, athletic and shapelier. One was 'brilliant,' at tennis, the other at basketball, whereas she was the uncoordinated 'fat and dumpy one.' Weight had been an issue at the centre of Wendy's life for as long as she could remember. She had dieted from early adolescence and recalled taking lemons to suck for lunch in a bid to stave off hunger when she was in high school. Discontent with her appearance, what she consumed and how that in turn consumed her, permeated her entire life: 'I think my weight is on my mind nearly twenty four hours of the day. You just get consumed by it' (Wendy).

As an adult Wendy was physically active and had played water polo in the same team for the past ten years prior to her interview. When I ask if there was a particular incident that prompted her to seek cosmetic surgery the theme of comparison was repeated: she was the 'heaviest' person on the team. Wendy went on to recount an event where she believed her appearance had been negatively evaluated by her team mates, but later in the interview she

became less sure whether the incident had been real or something she had imagined. While it is clear that Wendy's sensitivities regarding her body image were longstanding, the following events highlight how a negative evaluation of the self through the eyes of others might occur in a manner similar to the framework that Lewis (1971) describes. This incident heightened Wendy's self-consciousness about her appearance and immediately prompted her to limit her participation in training with her team to situations where she would not be subjected to the potential shame of unnecessary exposure. The ramifications of this event were such that she instigated plans to have cosmetic surgery to secure what she hoped will be a more permanent solution to her problematic body image. Her account illustrates how she internalised the negative appraisal of others to vicariously experience herself as flawed, which inflamed her already fragile body image.

Jane: Was there any particular circumstance that caused you to have a heightened concern about your appearance?

Wendy: About a year ago I was getting changed at the pool. A couple of women walked in and I had the distinct feeling that they were commenting about me. And actually I don't know whether there really was anything said, or I imagined it. But it was my impression at the time that they had been talking about me.

Jane: So you felt that people were making some kind of judgement about your size, did you?

Wendy: I did, yes. And I would say that most of the others in the team probably don't think like that, but there were just a couple of women like that and I thought, "Hmm, I'm the heaviest person on the team, so ..."

Jane: Do you think it made you more self-conscious about your appearance?

Wendy: It probably made me conscious of it; it probably did make me more conscious of it actually. Yeah, it made me more aware of it. And I've been playing with the club for ten years or so now.

Jane: And you never worried about how you looked before in that setting?

Wendy: No, no ... And actually, you know, they might not have been commenting about me, but I had the distinct feeling that they were.

Jane: Did you actually hear anyone say anything?

Wendy: No. No, I can't remember what I heard them say, but I think I must have heard them say something. It was just, just the expressions on their faces and the way they looked and I thought, "Yeah, they've been saying something."

Jane: And from that time did you start to feel differently about yourself?

Wendy: Well, I gave up training for a while on Sunday. I was definitely more reluctant to go to training. I can go home and shower of a night time and I did that quite often. But on Sunday mornings we have breakfast afterwards, and we all just go and jump in the showers together and strip off our bathers. There's no hiding behind towels or anything like that, you know, we're all very open. So, yes, I stopped training on Sundays after that.

There are a number of points to note in Wendy's account. Firstly, Wendy had assessed her body image as flawed from the time she was a child when her family's disdain for excess weight was impressed upon her and early dieting strategies were instigated to avoid becoming unacceptable in their eyes. This excerpt from Wendy's interview also reveals the fragile permeability of her self-perception and the ensuing heightened self-consciousness and self-imagining Lewis (1971:30) suggests is intrinsic to the shame experience. Wendy identified what she perceived as a negative evaluation emerging from a source external to her self, but she registered the experience as her own. It subsequently impacted her own self-assessment, confirming and compounding her already poor body image. For Wendy, poor body image pervaded her self-image. Lewis (1971) contends that shame is the vicarious experience of the other's scorn and Wendy's experience highlights how the negative evaluation made by others, whether real or imagined, became her own deeply felt experience. In keeping with the shame sequence that Lewis proposes, Wendy then withdrew from potential scrutiny by the other by attending training but leaving to shower at home. Wendy's account illustrates both the permeability of the relationship between the self and the other, while emphasising the separation between self and other in the subsequent and unambiguous underlining of the discrepancy between the two. The shame experience is Lewis reminds us, always implicated in defining and redefining one's own identity and the limits of its boundaries.

Wendy's account illustrates how a shame sequence particular to body image might be enacted. From childhood appearing 'as fat as a fat aunt' was upheld as abhorrent, as an example of what not to emulate. The dieting she embraced suggests that Wendy internalised a sense of dread that she, like her aunt, would be derided if she became overweight. It is against this backdrop of explicitly defined bodily preference that Wendy came to

increasingly view her own appearance as inferior which instilled anxiety about her weight that persisted well into adulthood. Within the previously benign setting of her sporting team, Wendy suspected that her appearance had been the subject of criticism and, as she recalled, whether the event was real or imagined was irrelevant to how it impacted upon her. It pushed her to re-evaluate her body image particularly harshly. Firstly, she withdrew from situations that might expose her body and her self to further shame and secondly, she planned to amend her body with surgery. The last part of the sequence, which has only been touched on to date, is the righting or restitution of the shamed state by surgical correction. In the context of this study cosmetic surgery came to be understood as occupying part of the shame sequence, a ritual of restitution where the body is cleansed of its tainting traits and amended, improved and absolved of its shamed state. However, Wendy did not acknowledge that she might have felt shame. She registered only that her body image had become unacceptable to her team-mates and herself. Her retreat from communal events with her team suggests that Wendy's flawed body image had afflicted her entire sense of self with shame. Wendy's account is particularly insightful as she had booked but not yet had cosmetic surgery at the time of her interview, and her articulation of the relationship between poor body image and shamed self, and how these processes came to be instated, is very clear. In her account, the values associated with female appearance were reiterated and conveyed in childhood. Wendy internalised her family's preferred model as her own and then spent much of her life struggling to attain it. Moreover, her family's preferred model of female appearance is also the preferred cultural model and they too, like the mothers in Van Raumer's etiquette manual (in Elias 1978) discussed earlier, have assumed the role of social emissaries of culture's vanguard.

Of course Wendy is not unique in her experience. The number of feminists to write on this subject is legion, and some have suggested that body loathing is such a common feature of contemporary female embodiment that it has become 'normal' for women to despise their curvaceous bodies (see for example: Wolf 1991; Rodin, Silberstein and Striegel-Moore 1985; Silberstein et al. 1987; Martin 2007). In much of the analysis put forward by feminists the rise in visual media is blamed for the collective self-loathing characteristic of contemporary female embodiment, but this study found the origins of this discontent were more convoluted

than linear and, significantly, much closer to home. While the terms body loathing or body hatred are accurate descriptors of the relationship which modern women all too frequently develop towards their bodies, these terms are highly problematic as they privatise a relationship that has its origins in collective social experience. It is too easy to marginalise women who hate their bodies by pathologising them as particular types of women obsessed by body image. Lay understandings also recognise body loathing as synonymous with a prosaic experience of female embodiment and isolate the afflicted woman as someone who should “just get over herself.” However, the debilitating effects of such loathing and the reasons why so many women experience it appear to be poorly understood in the academic literature. Silberstein et al. (1987) describe the continuum of eating disorders and the prevalence of unhappiness which women share around their weight and shape as a ‘normative discontent.’ They too ponder the omission within the academy to understand the problematic relationship women share with their bodies. They speculate that the academic tendency to value the mind over the body is a possible reason for this omission. The publication of *The Beauty Myth: How Images of Beauty are Used Against Women* (Wolf 1991) inaugurated a heightened interest by feminists and general audiences alike in the increasingly evident and highly problematic relationship which women develop towards their body image. A recent book by Courtney Martin (2007) covers similar terrain, describing body loathing amongst her generation, the daughters of second-wave feminists, as a normative state. Martin appears to be torn by loyalty to the generation whom she succeeds, and for whom she has obvious affection and respect, and the epidemic of self-destructive body loathing which she suggests is undermining and crippling the women of her own generation. The real tragedy of her book is that it demonstrates how little has been achieved in arresting the body loathing which Wolf (1991) defined a decade and a half earlier. Martin demonstrates considerable empathy as a researcher, eliciting chapter after chapter of painfully expressed data from her participants, but her lack of a convincing analysis as to why body loathing continues unchecked lets her argument down.

A possible explanation as to why rampant body loathing in women continues unabated may be that shame is implicated in poor body image. Theorists who have explored the role shame plays in interactive life and self-experience might suggest that any explanation of the way

body loathing is implicated in body image has as its first obstacle to confront shame, which is in itself deeply problematic, since the tendency to steer clear of shame is an inherent feature of its structure. Moreover, a general aversion to acknowledge shame is indiscriminate in the way it censors discussion, as social scientists have demonstrated considerable reluctance to subject shame to extensive scrutiny. Shame is undoubtedly painful and deeply confronting, but its inherent difficulties should not prevent consideration of its implication in the embodied anxieties which women share in negotiating body image. Having established a theoretical framework within which to explore shame, in the next chapter I look more closely at the experiences recorded for this study and what they might reveal about the ongoing construction of body image, how shame informs that construction and the role cosmetic surgery plays in the negotiation of body image.

Chapter Six: Evaluating Body Image

An inevitable question arises from both the examination of shame in the previous chapter and the participant accounts already presented: in what circumstances do women evaluate their appearance? Evaluation is, at its most basic, an assessment process undertaken to establish and attribute value. Lewis (1971) and Morrison (1989, 1998) denote failure to live up to a desired ideal or ideal self as implicated in the manifestation of shame. There appears to be some agreement (see also Nathanson 1987, Wurmser 1981) that these processes occur when the self measures itself against an ideal version of itself and concludes that it is inferior to the ideal. This study found that such failure was most frequently affirmed through the mode of comparison with a significant other. Lewis (1971:40) writes that 'shame involves a failure by comparison with an internalised ego-ideal' but the actual role of comparison in self-evaluation is something she only briefly touches upon. In this study the theme of comparison emerged as a significant orientating mode through which participants established a sense of worthiness or otherwise relating to their appearance. Schilder (1950) claims that the attitudes of others who are interested in our bodies also influences the formation of body image, and the perception amongst participants that significant others disapproved of, or devalued their appearance did appear to impact body image construction in negative ways. Many participants spoke of poor body image as something they had experienced from childhood. For some, interpreting body image as inferior was something a parent had encouraged them to feel. For others, negative self-evaluation emerged when they compared their appearance with another person who played an important role in their lives, and here sisters were the group most frequently nominated. Realisations of fatness, plainness or unusual height frequently entered a nascent self-consciousness in childhood or adolescent years, their painful origins identified as the result of appearance consistently being assessed as inferior, either overtly or by implication, by one or more significant others. Themes of comparison, criticism of appearance and, to a lesser degree, being drawn into a competition around appearance instigated by a significant other were important characteristics of the measuring-up process which participants spoke of undertaking, and which inadvertently affirmed that their appearance was inferior.

Many participants recalled their negotiation of body image as fraught and tenuous.

Ubiquitous and near-impossible images of flawless women found in visual media are often nominated as the templates against which women measure themselves. However, women in this study nominated comparisons with a previous version of themselves when younger, pre-pregnant, or thinner, or comparison with someone more intimately involved in their lives such as a family member, most frequently a sister, as more directly implicated in formative body image. When I discussed these findings with a participant towards the end of the field work, she confirmed what other participants had said:

Of course women compare themselves with a sister - who else would they compare themselves with? Because a sister has exactly the same genetics that you do: the same environment, the same food, the same school. Anybody else you compare yourself to, the basics are not the same, so comparing yourself to a sister is naturally what you do. And in fact it's the only logical thing to do (Patricia).

My early attempts to explore media images and the impact they have on the formation of body image were met with a certain degree of indignation by participants who expressed, on occasions, a notable irritation that I should think that they could not see past the airbrushing and manipulation in modern photography. They did not interpret media images as representative of real people, but rather as media constructions. They also understood the vast discrepancy between the lives of celebrities, complete with nannies, stylists and beauticians, and untold hours to labour on svelte bodies and flawless faces, and their own lives. Participants did, nonetheless, agree that media forms like women's magazines, television and the internet were informative, and indeed, primary sources for the dissemination of information about cosmetic surgery. However, as I found in one interview when a participant insisted that her intense dislike of cellulite had nothing to do with the way it is presented in women's magazines; there are difficulties in disentangling personal preference from wider cultural prescriptions of preferred bodily appearance. This particular participant was adamant that her opinion, that cellulite is both unsightly and undesirable, was arrived at independently and had not been influenced in any way by the derisive treatment of cellulite in women's magazines.

Cellulite provides a particularly clear example of the way in which the female body has been redefined in a modern context. Cellulite emerged as a derogatory classification of female appearance only part way through the twentieth century as women became progressively and publicly undressed and their bodies became increasingly fragmented into parts that were subject to escalating public scrutiny. Wolf (1991:227) identifies 1973 as the year *Vogue* magazine first described cellulite to a generation of American women, not as a normal variation of female appearance, but as an unsightly 'condition' indicative of flesh 'polluted with toxins.' Likened to poisons percolating at the most voluptuous of their margins, women *en mass* came to despise a physiological characteristic of their womanhood which the generations preceding them had never even heard of, let alone been concerned by. If we recall Nathanson's (1987) claim that the skin is the place where we hide, the public disrobing of women in the latter part of the twentieth century has seen layers of clothes steadily stripped away giving women fewer and fewer places to hide. As Roberta Seid writes:

No longer did a woman have the luxury of manipulating what was on the outside of her body ... now she had to manipulate her self, the once private stretches of her body ... Suddenly the average American woman became aware of flaws she never knew existed; pronouncements were made on how every private crevice of her anatomy was to look (1994:10).

More than a decade on, further exposure of the naked female body has occurred in the proliferation of internet pornography, and the scant layers remaining have been pared away with the practice of radical hair removal. In the wake of the Brazilian wax another surgical correction in the form of labioplasty has emerged. If we follow the idea of comparison to its logical conclusion it may be speculated that it is by comparing themselves with the images of women viewed in pornography that women who seek such surgeries measure themselves against. Either they themselves or others who view their bodies intimately must make such comparisons since there are limited contexts available to women where they can evaluate the appearance of their own genitalia as being in any way anomalous. Skilful use of media, and in particular advertising on the internet, demonstrates an entrepreneurial enthusiasm from within the cosmetic surgery industry to advance new surgeries like labioplasty. Moreover, new surgical procedures invariably shift classificatory frameworks and what once might have been considered a physiological variation within the normal range comes to be viewed as

deviant and moves closer to an anomaly requiring surgical correction. The very recent emergence of labioplasty illuminates the punitive drive underpinning the aesthetic regime and its proselytising trends: there are right and wrong ways that females and their genitalia should look.

While conversations like the one with the participant who hated cellulite highlight the difficulty in establishing a direct link between media projections of women and the enactment of cosmetic surgery, this study was more successful in establishing the way wider cultural preferences of female appearance are reproduced within the family. Significant others, in particular parents, are culture bearers. They are both the vanguard and the conduit through which the rules, values and preferences surrounding appearance norms are bestowed currency and subsequently embraced by successive generations in a manner which Elias' (1978) conceptualisation of the figuration makes clear. When it comes to body care and grooming, at the intimate interface of embodied social learning, the values surrounding appearance norms appear to be both internalised and understood from a very young age.

Feelings of inferiority surrounding appearance were most acutely voiced by women in this study who grew up in families where a distinct emphasis had been placed on appearance, and they progressively experienced their own body image as failing to meet the expectations of those around them. These self-evaluations were evident when participants spoke of another family member, most frequently a sister, as being much more attractive. Participants spoke of themselves as not only less attractive and less admired, but perceived themselves to be less valued and less loved. Findings from this research suggest that there is a link between a propensity for shame related to body image in childhood and poor body image in adult life. Such findings suggest that the dynamic of childhood socialisation is clearly influential decades later, and the undercurrents of its libidinal agenda may be implicated in the ongoing reframing of body image construction well beyond childhood experience.

Gina

Gina was in her mid-thirties when she was interviewed. She had been married twice, had three children and worked in middle management. She had her breasts augmented several

years prior to this study. Gina began her interview by explaining that she had been self-conscious about having small breasts as a teenager, particularly in comparison with her mother and sister, both of whom she described as having beautiful breasts. Gina compared herself to her mother and her sister in much the same way that Wendy described her relationship to her sisters in the previous chapter. I asked Gina whether she compared herself to other women in her family:

Gina: Oh constantly, not just physically but emotionally, just everything. There are a lot of emotional issues there. My mother is very outgoing and quite a dominant personality. And my sister is a completely different build to me, very petite, small and a personality that was so outgoing. She was gorgeous. She could do anything she turned her hand to and I just felt like a freak. This tall, gangly, no-breasted freak with big feet.

Jane: Many believe we are comparing ourselves with celebrities and we feel inferior next to them, but women in this study have not talked as much about celebrities as they have about.....

Gina: Their own families... (she interjects quickly)

Jane: Their own families, yes...

Gina: Because you're reminded every day. They are there every day.

Jane: Do you think growing up in your family there was a big emphasis placed on appearances?

Gina: Absolutely, my mother worked part-time for a local media organisation. She was always very conscious about her weight. We were constantly reminded about what we ate, what she ate. She would lose weight when she was coming up to do an event. It was everyday; I mean it was constant. So certainly, yes.

Gina spent her teens feeling self-conscious about having small breasts. In her early twenties she experienced something of a reprieve when she married a man for whom her breast size was not an issue. Nor was it for her until he had an affair with another woman in the year after their first child was born and then left her. Gina was breastfeeding at the time, an experience she found highly fulfilling. Not only did she derive great satisfaction from the experience of nourishing her baby but she enjoyed having bigger breasts and the feeling of being a 'real' woman they gave her. Gina interpreted this episode of her life through a prism of somatic repercussion. She recalled the events that transpired when her husband left her:

Because of the stress, my breasts went back to how they were and I had to give up breastfeeding. My milk supply just dried up. It was horrible. It was the worst feeling. I went from feeling like a woman for the first time and feeling really empowered and fantastic, and then to have my husband walk out on me and for my breasts to just disappear as well, it was really hard to cope with ... My breasts left and so did my husband. And I just thought, "I can't do anything about my husband, but I can do something about my breasts" (Gina).

She went on to say that this event brought up 'old issues' and revitalised insecurities from the past, but on this occasion it was clear to Gina where her options lay. Others in her family had had their breasts augmented. The question had always been posed, "Would she ever consider having it done?" When Gina lost control over the direction her life was taking, she opted to control what she felt she could, and that was her body. Two years after her separation, with money from her divorce settlement, Gina implemented two purposive investments to restore her fractured confidence. She resumed her studies in management and initiated plans to have her breasts augmented.

Gina set about researching breast augmentation in a diverse range of ways that included consulting with medical practitioners. Her surgeon arranged for her to speak with others who had had the same surgery. She read articles on the internet and collected images of topless women from men's magazines. This last method was recommended by her surgeon who was, she said, able to establish from those images the type of implant required to achieve her preferred 'look.' Apparently this is not an unusual practice, as another participant in this study was also encouraged to do the same. In an interview with a plastic surgeon working in New York, Glassner (1992) writes that *Playboy* magazine is a tax deductible expense for plastic surgeons. He cites the surgeon, who claims that the ruling cannot be disputed since *Playboy* is 'a tool of the trade in some practices' (Glassner 1992:197). Again, as in labioplasty, there is the suggestion that pornographic images are providing the template from which those who are dissatisfied with aspects of their appearance might re-imagine themselves if they were surgically enhanced.

Gina also took the unusual step of asking her friends, both male and female, for their opinions on the sizes and shapes of breasts. What is more commonly a backstage

phenomenon was, in Gina's case, enacted in view of friends, family, colleagues and classmates. Her rationale was that if she was going to go through with breast augmentation she would find out what others, including men, found attractive in the appearance of breasts. In seeking the opinions of others Gina also makes it clear that, for her, becoming desirable to herself was synonymous with becoming desirable to others. Gina wove the experience of her breasts into her life story. She attributed to the surgical enhancement of her body a powerful curative potential which could reconstruct not only her body, but herself as a whole. Pre-surgically and imaginatively she rejected and detached her inferior breasts and recast them as an embodied motif into which she poured all that she perceived was wrong with her: her failures, her flawed sense of self. As such they became a metaphor symbolising both problem and resolution, and through surgery, other less tangible problems of the self were resolved. All surgery is highly ritualistic, carried out in theatrical spaces with the players assigned particular roles, designated costumes and prescribed codes of conduct which must be staunchly adhered to. Anaesthesia induces a death-like sleep and surgical instruments probe and penetrate the margins of the body which demarks its parameters into clean and dirty, normal and abnormal. Emerging from any surgery the body is always transformed. In cosmetic surgery the ritualistic aesthetic of transformation is actively sought but, as Gina's account makes clear, the effects of transformation associated with cosmetic surgery may extend beyond physiological appearance alone. She attributed her breast augmentation with inaugurating flow-on effects which amended her self as a whole. She articulated this transformative shift as a move from obscurity in the shadows cast by others to confident self.

There is not a day that goes by that I don't look at myself and think having my breasts augmented was the best money I could have ever spent on myself ... I was very much my ex-husband's shadow. I had always been a shadow of somebody; I'd never really known who I was. And they say "Oh, you know, plastic surgery won't change how you feel," *well frankly, bullshit!* It changed *everything* about how I felt. I just felt completely different; a confident, out-going person. That process had also involved meeting a new set of friends, going back to school and going out and discovering who I was for the first time in my life. But yes, having the surgery certainly just pushed me up the scale in confidence (Gina, original emphasis).

While Gina's claim that having bigger breasts had enabled her 'to know herself' is, on many levels, deeply confronting, she herself is very clear in linking her poor body image to an incomplete sense of her own identity. It had always been there, the feeling that she was somehow lacking: that she was not pretty enough, not clever enough, not good enough in comparison to those around her. Moreover, she used the event of having surgery as a transformative and interactive performance, as a way of positively engaging the attentions of those around her. She directed the gaze of others towards her flawed breasts and sought their input about how she might positively alter them. Pulling the veil from such a private experience would be the brief of the cosmetic surgery reality makeover programme, and one of the effects of this genre has been to normalise cosmetic surgery by thrusting open backstage doors to reveal the intimacies of surgical grooming. Exposing what was once hidden, private and shameful makes it less so. For many in this study, having cosmetic surgery remained deeply shameful but Gina circumvented potential shame by making her breast augmentation something of an interactive event. In canvassing the opinions of others about what they found attractive in the appearance and size of breasts Gina demonstrated a willingness to recast her troubled body image as a co-production in which the input of others, their care, interest and engagement was actively sought and welcomed. Moreover, it was this very openness that enabled her to transcend the shame she almost certainly felt as a teenager and in the aftermath of her husband's rejection. In retelling the story of her breast augmentation as both a spatial and social shift from shadows to centre stage, Gina located her surgical experience within the transformative trajectory of shame to pride.

Like Gina, most women spoke not just of having cosmetic surgery but of their experiences of embodiment more generally, weaving together notions of self-love, body-love and their highly complex interactions with others. They spoke of their relationships with their mothers, sisters and partners and how these interactions shaped and informed their own feelings about their bodies. Their body images were not unique, autonomous formulations, but the multifaceted co-productions emerging from interpersonal interaction which Schilder (1950) described. Participants also spoke of puberty, maternity, weight fluctuations and ageing, weaving biological change at the level of the body into the experience of the self. Their experiences of embodiment had been, to varying degrees, distracting and distressing,

emphasising the complex role which body image plays in the construction of the self. For women, body image is a fluid, constantly changing and highly personal phenomenon, experienced within a cultural framework constrained by overarching disciplinary values and regimes. Experiencing one's body image as anomalous within these wider structures frequently implicates the totality of self-experience and, left unresolved, has the potential to be deeply wounding. Those most acutely affected in this study came to their own realisations of physiological anomaly very early in their lives, when the people they loved and trusted most impressed upon them their failure to live up to their expectations.

Kate

Kate described a long and difficult relationship to her body image. Like Gina, she grew up in a family where appearance was extremely important. Undercurrents of competition and comparison around appearance informed her relationship with her mother and sister from her earliest memory, and continued to impact upon how she related to her body image. When interviewed, Kate was in her early fifties. She had been married once, but divorced five years earlier following the exposure of her husband's infidelity. At the time we spoke Kate was single. She had adult children, was tertiary educated and worked as a specialist consultant. Kate grew up perceiving herself to be the fattest in her family, overshadowed by a slim and attractive mother and an equally slim and attractive sister, with whom she felt she was negatively compared. Body issues were woven through the lives of Kate, her mother and her sister. They had all had cosmetic surgery. Kate's mother had her breasts augmented first. Kate and her sister had both had their breasts reduced. Both Kate and her mother had an abdominoplasty and Kate also had numerous cosmetic facial procedures. As she spoke Kate's voice became louder, more angry. Her mother and the legacy which her appearance regimes instilled within her as a teen were still plainly evident.

I would say that the amount of cosmetic surgery that I have had definitely reflects back to how I was treated as a teenager, how my parents treated me, and especially my mother ... When I was a teenager my mother used to dress me much more like an older lady, like a thirty year old. She ran a deportment school. She was very skinny and very attractive and she was in competition with my sister and I. She used to compete against us and how we looked. I was slightly plumper than my sister who was quite skinny, and she was allowed to wear mini skirts and did

some modelling and stuff like that, whereas I was dressed as an older lady. All my clothes were the clothes old women wore ... My mother always said I was fat. She told me I was fat so many times ... I wasn't allowed to wear a mini skirt because I was too fat ... She said it to me so many times: *"No, you can't wear a mini skirt, you're too fat."* She said it to me lots, lots and lots ... Mum was selfish and domineering and she now lives in a fantasy world about what our lives were like and what she did to us and how she treated us. She's often said to me, "Oh, you were such a good teenager Kate," and I feel like saying, "There is a whole pile of history that impacted so drastically on me. I was rebelling against all of this crap you were pouring onto us because you wanted to be an attractive sexual being" ... It was all so important to her, how skinny she was, what she looked like, the clothes she wore, the jewellery she wore, the attention that she got ... If you brought something that looked really nice on you and mum thought it would look better on her, she would just take it from you (Kate, original emphasis).

Kate grew up in an environment where a great deal of attention was focused on appearance. Eventually the derisive taints of fatness became unbearable, and as a teenager Kate's struggle with her weight spiralled into bulimia nervosa. In her early twenties she managed to contain the bulimia but her body image has remained a contested site and managing her weight through ongoing dieting has been a persistent feature of her adult life. She still compares herself to her sister: 'She's not skinny anymore but she's very trim and muscled and one of the reasons why I'm trying to lose weight now is that I will be seeing her at Christmas ... She is bringing her new boyfriend ... and yes, it *is* important' (Kate).

Kate readily admitted that her marriage was in trouble long before her husband had an affair with a woman she described as much thinner than herself, but her immediate reaction was to lose weight. Although she was well aware that her size was not the reason her husband became involved in an affair, Kate played out her rejection in comparison and poor self-evaluation at the level of her body image. She did not consider other reasons as to why her marriage might have failed: instead, she loaded her body image as the repository for all her failure. Like Gina above, body image, always subjectively interpreted and inherently plastic, became the frontline motif through which questions of her selfhood were played out.

My husband had an affair when I was fat and that was one of my main motivations for losing weight because ... she was very tall, very skinny ... and I was huge. I certainly lost the weight because of the affair. I certainly did that because I felt, "She's skinny, therefore something's wrong with me and that's why he had the affair," which is not true anyway (Kate).

Kate's readiness to see herself as physically flawed is central to the shame she has felt about her weight since she was a child. As an adult this is reinforced by the competitive defeat and sexual rebuff which Lewis (1971:29) suggests are contexts that lend themselves specifically to negative self-evaluation and a subsequent proneness to shame. Body image had always been a site of vulnerability upon which Kate's sense of worthiness and the perceived conditional love of intimate others had been based. Even though she knew that her appearance was not the reason that her husband left her, she could not refrain from comparisons and inflicting regulation upon her body to amend its appearance. Being a bigger woman who had lost vast amounts of weight at various times during her life had enabled Kate to reflect upon how differently she was treated by others depending on her size:

I went into a meeting when I got to about seventy kilos. It was with people I'd seen around but had not been involved with before. I'd changed jobs, and five of the men in that room came over and helped me get a chair. Five of them wanted to make me a cup of tea. They all paid me attention. Now, I didn't exist in their minds when I was one hundred and five kilos ... I was totally invisible when I was huge (Kate).

'Invisibility' is the plight of the unacknowledged social self 'unworthy of attention at all' (James 1950:294). As a bigger woman, Kate was acutely aware of the biases contained in cultural preferences around female appearances. She had spent time in Fiji, where bigger women are much admired, and contrasted her experiences there with her experiences in Australia, where she was virtually ignored when she put on weight. Later in the conversation she compared the attention her thin, blond girlfriend receives whenever they went out together to the scant attention she herself received. The way Kate described her body image indicated that it was a highly labile construction which was dependant on the input of others. How she felt about her body image was tied intimately to the type of feedback she received from others. A recent lover who appreciated her voluptuous form made her feel more

beautiful than she ever had, but when he moved on her body image was again unstable. Her boundaries are, as Lewis (1971) would have it, soft. When I ask Kate if she believed that she initiated cosmetic surgery for herself or others, she again emphasised her weight and stressed that social contexts were the milieu in which her feelings about her body image were consistently mediated:

My weight is certainly an issue, how I see myself in the mirror, but also in attracting a partner of some kind, or a companion. And it's very hard to be suddenly at forty-five, to be alone and know that if you are going to have a partner you have to go to bed with another man. I was young with lovely skin and quite a good looking body when I got married at twenty-six, it's a different matter to go to bed at fifty with someone you don't know well and who hasn't seen you in those lovely blooming teenage years (Kate).

There is poignancy in Kate's response. She articulated a vulnerability that many women experience in re-partnering and re-entering the libidinal economy. Like most women her age, her post-gravid, mature body differed from the so-called 'ideal.' Her body, with its inscriptions of past illness, pregnancy and age, was undoubtedly within the range of normal, but because perfect young bodies are the most visibly available her naked reality is skewed to feel deviant. Bright, successful women like Kate have great jobs and good incomes but they cannot escape a cultural inheritance deeply invested with unrealistic notions of female appearance. Naked, she felt both physically and psychically exposed. She feared a potential partner's evaluating and critical eye and, in the same instance, his potential, painful, shameful rejection. Lust and sex are at the forefront of early relationships but in the exquisitely sensed intimate interactions of nascent love his imagined ideal may exceed what she is able to offer, and crushing shame may swamp and engulf the self. Shame, in our culture at least, Lewis (1971:16) writes 'is probably a universal reaction to unrequited or thwarted love.' Why 'she' perceives herself to be 'his' object of desire and he the critic of 'her' body is part of the monolithic structure of gendered aesthetic inequity which future generations need to challenge, deconstruct and disassemble. Women in this study like Kate have come to question the inconsistencies and inequities of such a pervasive and keenly felt structure but she, like most women, has been socialised in its shadows. Here shame thrives, contained and concealed in our most private experience. Shame contains and constrains

private experience, and it is this same privacy that allows the unfettered proliferation of shame to inform the social structures that loop back and shape private experience. When women say they have cosmetic surgery for themselves, they are privatising what is in fact a social phenomenon. Social and self-acceptance is always impacted by the opinions and actions of others, as Cooley (1964) and James (1950) make clear, and although cosmetic surgery may improve the self-image of individuals by amending their poor body image, it does little to address the underlying structures that perpetuate the ideals of perfection which undermine and disembody many women. If anything, cosmetic surgery only serves to strengthen and perpetuate their hold.

Erin

Erin was another participant who nominated comparison as the mode through which she assessed her body shape as inferior. She was in her fifties when interviewed, was in a stable relationship and worked as an allied health professional. Her parents died when she was a young woman and she had no sisters. Her closest family were two brothers, their wives and children, and it was from within this group of significant others that she found the templates against which she chose to compare her own body image. Erin considered having breast augmentation in her twenties, and went so far as to consult with a cosmetic surgeon. Following lengthy consideration she decided not to proceed. More recently she had two lots of liposuction to her thighs. Her dissatisfaction with her body image was linked causally to comparative behaviour:

Jane: So how do you think that it happens that you come to dislike the shape you are?

Erin: Well you, you make comparisons with people who're around you I suppose. I'm surrounded by my sisters-in-law and nieces, who are, you know like twigs with tits (she laughs, but it is short, sharp and self-deprecating) ... My thighs were huge. They got really enormous. In the end they did. They were as big as people's waists. *OK*, my thighs were bigger than my niece's waist (there is anger in her voice). Now one of my nieces is slim, she probably had a 25 inch waist. That's, it's about a size ten. It is very slender. But my thighs were 27 inches. I think when my thighs are bigger than my niece's waist, even though she's slender, well you don't really feel too good about yourself do you? The top part of me could be quite small, you know, but the thighs were a real battle. Oh, I suppose if I did work really hard and dieted really

hard they did go down, but it was an awful effort to sustain, because I didn't naturally have thin thighs.

It was evidently painful for Erin to admit how anomalous her body image became. Speaking aloud and describing her flawed body image the anger in her voice is unmistakable. She used self-deprecating laughter in an attempt to neutralise and bypass (Lewis 1971) the anticipatory shame which her next sentence contained. This attempt fell somewhat short, and her anger in the sentence that followed: 'OK, my thighs were bigger than my niece's waist' is deeply shame-laden. Erin's use of the collective 'you' in 'well you don't really feel too good about yourself do you' was another strategy to diffuse the pain her shame elicited in her self-conception. In using 'you' she attempted to both bypass shame and normalise how she felt by suggesting that I, as the witness to her shameful confession, would feel the same if I were to find myself in a similar situation.

For Erin, negotiating body image was an ongoing and bitter 'fight with nature.' She described her body as 'pear shaped' and understood that the way she looked 'was probably how women are supposed to look,' but she also understood that her shape was at odds with a current cultural ideal that favours Pamela Anderson types: small, thin women with big breasts. Years of dieting and regular gym work had failed to alter her natural shape or arrest her sense of rising frustration. She described herself as literally reaching a point of 'anger' that her considerable efforts to change her shape had 'failed.' Furthermore, it was her ensuing anger, directed toward her resistant body that finally propelled her to have two extensive liposuction surgeries. For Erin, Kate, and many others in this study, it was being outside the cultural ideal of the preferred female form that was so deeply wounding to their body image and self-conception. However, it is the acceptance of those preferred ideals and the consistent reiteration of their embodied value by beloved parents, sisters, friends and relatives that make the interface with something so abstract as a culturally constructed form of feminine ideal so personal, private and deeply hurtful. It is not the images on their own that are wounding, rather, it is the embracing and acceptance of the values invested within those images by significant others who, in turn, influence the body image construction of those with whom they interact intimately which is problematic.

"I was always told ..."

If shame is, as has been proposed here, implicated in internalising the perception that one's body image is inferior and fails both the expectations of significant others and the self, then a question yet to be addressed arises: from where then do such expectations emerge? In many accounts already presented the role of one or both parents in the construction of body image has been noted. The influence of parents on the construction of body image was voiced consistently across the interviews. What was also striking was how influential these formative experiences were in the lives of adult women. The next section examines more closely the complexity embedded in the relationship between body image and early socialisation

Patricia grew up as the oldest child with three slender sisters. She described herself as significantly bigger than her siblings and recalled her mother put her on diets as a teenager and made her clothes that she detested, while her sisters wore store-brought dresses. Patricia was interviewed when in her early sixties. She was married and held a senior position in a public company. She had an abdominoplasty over twenty years earlier and had recently had a facelift in the weeks before we spoke. The anger she retained about the advice given to her by her mother as a teenager was unambiguous:

My mother used to lie to me. She'd say blatant lies, like when you go to university people won't worry about what you look like, they'll just think about how you think and who you are. *That's a complete lie!* It makes no difference where you are as a young woman. People, men, when they get to know you might take you out, but if they are at a party they don't go for the fat one in the corner. They go for the slender, beautiful one over there, which is quite natural. So she wasn't telling the truth. *I hate them. I absolutely hate lies* (Patricia, original emphasis).

Anger around the pre-emptive advice given by parents about how their daughter's appearance would be received in the eyes of adult men was also voiced by Sarah. Sarah grew up continually being reminded of her difference and was told, mainly by her parents, that because she was taller and bigger she would not be attractive to men. Sarah was in her thirties when we spoke. She had laparoscopic banding several years earlier and more recently a breast lift and abdominoplasty to remove the loose skin that remained following

considerable weight loss. She too reported 'always battling' her weight and is in no doubt the self-consciousness she felt about her size was something her parents made her feel:

My father told me I looked like a boy, which didn't help matters much. And my mother was always saying: "*Shoulders back, chest out, suck your stomach in, you've a big gut.*" She was always putting me on a diet because I was on the chubby side, that sort of thing ... I was very different to my sisters who were much shorter and smaller in stature than I am. I was always made to feel different, because of my size ... I was always told, "*Oh, you're a big girl.*" And those things stick in your mind as a child and you carry them with you until eventually you realise that it doesn't really make any difference. And I don't think I really realised that until I had left home and started going out with boys. They didn't seem to mind. So I thought, well, maybe I'm not so bad, maybe there is nothing wrong with being tall and busty. But it took that long to start, and I say *start*, not really realise it, but *start* to realise that it was OK to be the shape that I was (Sarah, original emphasis).

The linking of negative body image construction to the views of significant others is captured in an oft repeated sentence that began "I was always told ...". Wendy and her sisters were always told 'they would end up as fat as a fat aunt if they were not careful,' Kate's mother 'always said I was fat,' Sarah recalls that she was always told 'oh, you're a big girl' and Lillian (below) said she now looked back at photos of herself as a teenager and thought 'I possibly wasn't as bad as I had been told.' Poor body image formation in childhood for the women mentioned is something of a contradiction because it coexists, albeit silently, in a childhood experience of otherwise loving relationships with parents. Parents are generally the custodians of their children's bodies, but care is also a form of epistemology. In the process of caring, caregivers socialise their children to acceptable social rules of embodiment and in doing so they also transmit wider preferred cultural values around appearance. Parents generally, and mothers in particular, groom their children to aspire to be as close to the cultural ideal as possible. Moreover, their actions are generally well intended since parents commonly believe that the lives of their daughters will be enhanced if their appearance is pleasing. Caring is also a form of social grooming.

Many participants were well aware that the legacy of their parents' intervention in their body image formation had been devastating, but these effects tended not to be discussed. Their silence is, in all likelihood, related to the privacy that characterises the shame experience, which in these instances overlays the original shame of failed body image. In addition many participants acknowledged that their parents, and in particular their mothers' own body image agendas had impacted upon their own. These observations raise the possibility that it is maternal shame and her failure to live up to an embodied ideal that a daughter subsequently internalises. Before considering the dynamic surrounding the intergenerational transmission of body image shame I wish to consider the experience of a participant I have named Lillian. Lillian gives one of the clearest enunciations linking poor body image formation in childhood to an ongoing tendency to shame in adulthood.

Lillian

At the time she was interviewed Lillian was in her fifties. She was divorced and had adult children. Lillian was tertiary educated and worked in senior management. She had an elective laparoscopic band surgically inserted as her most recent attempt to lose the weight which had been a consistent feature of her experience of body image from early childhood. Lillian presented as a dignified and quiet woman. There was an air of reflective sadness surrounding her. Over the course of the interview it became clear that for her, like many older women whose accounts have been presented in this study, reconciling body image dissatisfaction in the present demands revisiting and re-examining the past. Medical intervention might amend body image temporarily but the shame which failed body image engenders may require more introspection. For Lillian, poor body image had been a major focus of concern and she had spent many years attempting to understand the role it had played in her life. Through the interview I was given a sense of her ruminations. They played a functional and necessary role in reconciling the past as she continued the long process of rehabilitating herself to the present. For Lillian, reflexively reviewing the past and extricating a sense of herself from the overwhelming expectation of others was a form of emotional wound care.

Lillian: When I was very small I remember being in a dance class with a tutu on and coming off the stage and mum making some comment about me being a baby elephant. I must have been about eight I reckon. So I was overweight then, and all through my teens I was dieting. In fact I have dieted all my life, lost weight and put it on, lost weight, put it on ... Always ... I lost it in my teens, but I still thought I was overweight and when I look back at photos now, I think, "Gee was I really that thin." But I had an image during that time that I was overweight. So I quite possibly wasn't as bad as I had been told. I think a lot of that had come from my mother. She had told us that we were overweight. And maybe it was related to her weight and, in fact, I took that on board or something. I don't know ...

I married in my early twenties ... My husband was obsessed by looks, very much so. He is perfect; his own image is perfect. We were together for twenty years, but I believe his mirrored image of me cracked and it impacted upon him and so he left me for someone that looked a bit better. I really believe that ... (It was) *shocking*. And that rejection; and that insecurity was what I think I had in my childhood. And I think that rejection compounded that insecurity. And it's taken me until this time in my life to accept, to recognise that rejection in me and to recognise when someone rejects me.

Jane: Was that rejection you felt as a child related to your body size?

Lillian: Probably, yes

Jane: So it has been very important through your life?

Lillian: Yes, yes, definitely. I can remember thinking when I was eighteen: "It will be alright. By the time I'm nineteen I won't be overweight."

Jane: And you dieted?

Lillian: Yes. I can remember saying that to myself: "It'll be alright, by the time you're twenty you won't be overweight." I'd have these goals that were never ever achieved because I still thought I was overweight. Now, as I said, looking back at the photos, I wasn't as bad as I thought I was ... I don't know now whether the driver (to have weight-loss surgery) was just one thing. I started to get ill. My blood pressure was up, my knees were bad, my back; all those things. I was uncomfortable as well. But it was the image thing too and me probably thinking, "Well I am on my own now; maybe someone will love me if I'm thin" (short laugh). I don't really believe that. I don't believe I want that sort of love anyway. But you can't help but sometimes think that.

Jane: That you are unworthy of love ...

Lillian: Because you are overweight. And that's definitely how I felt after my divorce, but my self-esteem was very low then.

Jane: Did you go through depression ...

Lillian: Very badly, yes; because it was such a shock to me, *a total shock*. And I was really ill, very ill for twelve months. I couldn't do anything (original emphasis).

By her own account Lillian's husband was fastidious about his own body image and it was important to him that Lillian, as his wife, conform to the image *he* wished to project to the world. He wanted her image to mirror his, and because his own standard sought perfection, he wanted her to appear perfect. Their home, their car and their children were all required to present an image of perfection. Elsewhere Lillian recalled her husband was particularly interested in her appearance: what clothes she wore, how her make-up was applied and how her hair looked. He actively groomed Lillian as part of his public image. After they separated Lillian's friends told her that they were 'horrified' when her husband had reprimanded her by instructing her to correct her posture and pull in her stomach in front of a group of them one evening when they were all out together. Lillian's voice was full of sadness as she recalled how she had 'idolised' her husband so much that she had not noticed, nor could she have admitted how pervasive his influence was in managing her body image. As she reflected back upon her marriage she now saw that his fixation on image was never-ending and it was likely that he would have always found fault with her. She said resignedly, 'He was very much into image and probably I could never have been perfect enough.' She added: 'It wouldn't have mattered; if it wasn't my weight it would have been something else ... Image was very, very important. And still is' (Lillian).

Fifteen years had elapsed since Lillian divorced her husband but rawness and sadness were still evident as she spoke. She had weight-loss surgery three years before our interview and had successfully lost half the weight she wished to lose. In the years since her divorce Lillian had been to university, and arrived at a position she found both socially and intellectually stimulating. She was in a comfortable relationship with a man who was, by her account, not interested in anything to do with her appearance. Yet the fragility of her body image persisted in permeating her life. Lillian's desire to lose weight continued to occupy a vast amount of her time and emotional energy. Despite being well on the way to her weight-loss goal and having expended considerable reflexivity upon the genesis and evolution of her

poor body image, Lillian was still unable to confront her own image in the mirror. The cumulative effect of poor body image in her earlier life, during her marriage and the recurrent theme of rejection were seen by Lillian to have residual effects. Shame continued to inform her body image and pervade her sense of self well into adult life. Lillian was reluctant to shift blame for her body image issues to her mother, but in retrospect she came to believe her mother's negative body image influenced her own formative body image, which had ongoing consequences into her adult life.

There can be little doubt that Lillian experienced her body image as something deeply shameful. Her successive failures were the failure to live up to the expectations of others. As a pre-adolescent and adolescent she failed her mother's expectations and during her marriage she felt she failed to live up to the appearance expectations her husband had defined for her. Being replaced by 'someone who looks a bit better' makes it clear that shame relating to her failed appearance was central to Lillian's self-experience. Shame was also evidenced in her use of the term 'rejection' and her demonstrable understanding of the consequences her failure produced. She was reluctant to admit, but could not deny, an underlying certainty that being a worthy recipient of love was conditional on being thin. This admission provided additional evidence of her deeply felt shame about being a bigger woman. Lillian herself did not mention the term 'shame' and it was only in the process of re-analysing the data and with further reading that I came to see her experience of body image as deeply imbued with shame. Lillian's account raises a number of additional questions about the imposition of expectations of those around her and how they contributed to her experience of shame. I was struck in particular by two comments Lillian made about the influence of significant others on her body image. The first related to her mother's own body image dissatisfaction and how it subsequently impacted upon her body image, and secondly, her description of her husband's efforts to mould her body image to be one that mirrored the image of perfection which he wished to project to the world. In retrospect Lillian did not see her identity as being separate from his, but as something that mirrored and reflected his. His investment in her as an object to enhance his own public image introduces the question of narcissism and how it might be understood in relation to shame.

Freud on "normal" narcissism

Clinically, narcissism is considered to be a personality disorder, where the love of self has replaced the capacity to love others. Psychoanalysts tend to write about narcissism in the context of pathology, but Freud considered that a degree of narcissism was required for good self-esteem and argued that narcissism is, in part, normal (Storr 1989:43). Freud believed that everyone directed their libido both externally towards others (object libido) and inwardly towards themselves (ego libido). In his essay *On Narcissism: an Introduction*, which was first published in 1914, Freud (1957) cites illness, being in love and parental narcissism as contexts where self-absorption could be observed as occurring normally. The last two examples, contexts where libidinal investments implicate others, are of interest to the present discussion. Freud denotes being in love as the highest form of libidinal investment in an object external to the self, but when libidinal investment is not reciprocated an imbalance occurs where one party absorbs more libido as the other becomes impoverished. I venture here a suggestion that such an imbalance occurred within Lillian's marriage, where her husband's investment in their relationship benefited his own ego and occurred at the expense of hers. His investment was, as she described it, in all probability highly narcissistic. His interest in her was to 'mirror' the image of perfection which he hoped to project to the world. From Lillian's perspective, his rejection of her occurred because her body image ceased to flatter him. His self-absorption and interest in her as a flattering object meant she was both dispensable and replaceable. In the fallout from their separation Lillian spiralled out into a morass of deep mortification, or shame. It will be recalled that Freud himself did not focus his attention on shame. In the essay *On Narcissism: an Introduction*, Freud (1957) introduces the concept of the ego-ideal, which he subsequently abandoned in favour of the superego. Lewis (1971) uses both these conceptual ideas in her formulation of shame. Many shame-focussed authors to follow Freud have pondered his omission (Morrison 1989, Kilborne 2002) and many believe that he may have identified shame if the concept of the ego-ideal had been developed further. However, such pondering is part of another discussion which is beyond the scope of the present study.

For my purposes I wish to draw attention to the narcissistic investment which parents invariably direct toward their children, upon which Freud comments. Freud identifies

parental love as a form of narcissism. Parents, he suggests, revive their own narcissism by investing in their children as they had once narcissistically invested in themselves. Their feelings are characterised by overestimation, a feature of narcissistic investment. In describing the narcissism enacted by parents he writes:

They are impelled to ascribe to the child all manner of perfections which sober confirmation would not confirm, to gloss over and forget all his short comings ... Moreover, they are inclined to suspend in the child's favour the operation of all those cultural acquirements which their own narcissism has been forced to respect, and to renew in his person the claims for privileges which were long ago given up by themselves. The child shall have things better than his parents; he shall not be subject to the necessities which they have recognised as dominating life ... He is to fulfil those dreams and wishes of his parents which they never carried out, to become a great man and a hero in his father's stead, or to marry a prince as a tardy compensation to the mother (Freud 1957:48).

Parents frequently invest great love in their children; hope for a better future and, with it, the expectation that their progeny will succeed where they themselves have failed. Freud himself acknowledges the potential difficulty that the weight of parental narcissism might hold:

The disturbances to which the original narcissism of the child is exposed, the reaction with which the child seeks to protect himself from them, the paths into which he is thereby forced - these are themes which I shall leave to one side, as important fieldwork which still awaits exploration; the most important of these matters, however, can be isolated from the rest ... as the 'castration complex' (Freud 1957:49).

At this point Freud parenthesises the castration complex as penis anxiety on the part of the boy and penis envy for the girl and thus posits anatomical insufficiency as the central feature of the 'castration complex.' For my purposes it is more useful to consider castration as the metaphoric exclusion which Elliott (1992) proposes, as was discussed in Chapter Five. The model of shame which has been developed in this study posits that it is the failure to live up to the expectation of a significant other that the shamed person internalises and accepts as their own. The constraining feature of shame is identified as the fear of rejection, or the

metaphoric castration, which accompanies it. As examples from the data have shown, the way these expectations are developed is not uniform. They may emerge from a range of contexts in which the 'other' is deemed significant and may even be imaginary, as Wendy's account in the previous chapter demonstrated. However, there is considerable evidence presented in this study to suggest that failing the expectation of either or both parents is also a key context from which a seminal sense of failure might emerge. Making a definitive claim that there is a connection between parental narcissism and shame around body image is perhaps overly ambitious in the present instance, but the evidence uncovered does raise the possibility that such a relationship may exist. In the same way parents imbue their children's lives with their own narcissism, children too may internalise their parent's subsequent disappointment as they grow and it becomes clearer that they are failing to realise any pre-determined hope or expectation about how they perform, or how they look. Parents quite naturally want to feel proud of their children and if their offspring reach or exceed any expectations they harbour there may well be no problem, but in the event of parents being disappointed by their children's efforts the child may internalise parental disappointment as a sense of failure, as shame. This may be even more likely in the case of body image when a despised genetic characteristic that is outside the cultural ideal and which a parent has long battled themselves becomes evident in a daughter. Here we reach a connection between what might be considered 'normal' well-intentioned parental narcissism, expressed through pride and shame, which depends upon a parental aspiration being fulfilled or otherwise. Lillian's mother's comment that she looked like an elephant in a tutu may have been an attempt to bypass the embarrassment (or shame) elicited by her daughter's appearance in comparison with thinner girls in her dance class but, four decades on, Lillian recalled her mother's comment as her earliest recognition that she was fat. This was a significant moment for Lillian and illustrates how intergenerational shame might be transmitted. From that moment Lillian became aware that her mother thought her fat and was ashamed of her appearance. Moreover, from that moment on her mother's shame progressively became her own shame. Gina, Kate and Lillian had been drawn into the orbit of their mothers' body image concerns. Within the figuration (Elias 1978) of the family, maternal body image attitudes frequently provide the template through which daughters learn to become socially embodied. Care-givers are the guardians of that embodied knowledge. They socialise their daughters to care

for their bodies independently, conveying the art of self-presentation while inadvertently emphasising and de-emphasising particular values in physiological presentation. In re-examining the vast toll which poor body image had inflicted on her own life, Lillian came to realise that as a child she has assumed her mother's body image dissatisfaction as her own. Her body image shame was, like her propensity for a fuller figure, inherited from her mother. The self-loathing her mother felt towards her own body image was something Lillian learned and embraced as her own. Theirs was the shared shame of narcissistic injury, of living outside a cultural ideal that reviles bigger women.

In suggesting a potential link between parental narcissism and shame we reach delicate ground. While many participants acknowledged that parental intervention in formative body image construction had been deleterious, most understood their parent's actions to be well-intentioned and informed by a wider cultural framework which privileges particular values surrounding female appearance. These understandings did not, however, absolve the anger which some participants still felt towards their parents, their mothers in particular, as the accounts above demonstrate. Kate's account provides the clearest example, but even she had been unable to confront her mother. This may be because her mother plainly recalled a different version of events regarding her childhood, and the outcome of any such discussion, many years after the fact, might be deeply hurtful to her mother, who it appeared was oblivious to the damage her interventions had produced. Freud (1957: 49) reminds us that parental narcissism is, at its heart, both touching and childish. It is also an investment imbued with love, hope and, in all likelihood, the very best of intentions. His discussion of narcissism highlights a perennial feature of parental love and how readily parents unwittingly fail to acknowledge the separate identity of their children, but instead view their offspring as extensions of themselves. Bearing in mind the tension of competing narcissisms at play within the familial unit, the primary narcissism of the child and the much less widely discussed narcissism of the adolescent might serve an additional function by enabling growing offspring to extricate their own identities from the narcissistic hold of the parent. Their evident self-absorption enables experimentation with a range of identities beyond those prescribed by parents. Certainly the narcissism of the adolescent can temper the unconditional passion a parent once felt for their child, playing an important functional role

in the way it prepares both adolescent and parent for the inevitable separation that will come as the adolescent emerges from the familial unit and moves into the wider social domain.

Both separation and shame require looking towards the self and engaging the re-evaluation, reappraisal and rehearsal required to then shore up and re-establish its boundaries. These enactments seek to restore not only self-love but also the love of the other which is foundational to social acceptability. Amending shame, therefore, might also be understood to engage processes that could likewise be termed narcissistic and I will return to these themes in the final chapter. In the chapter to follow the focus remains upon shame but considers different participant accounts in order to extend the discussion of shame from body image to an exploration of the way in which shame is implicated in the enactment of cosmetic surgery.

Chapter Seven: Shame and Cosmetic Surgery

The information sheet circulated for this study asked potential participants to consider what had shaped their decisions to undertake cosmetic surgery, and how having cosmetic surgery had impacted upon their lives. The eventual participants proved generous and thoughtful in terms of what they brought to interview. We were covering delicate, deeply personal ground but it was apparent that the prospect of the interview had prompted many participants to revisit their circumstances and their reasons for having cosmetic surgery prior to the interview. A smaller number, noticeably more tentative at the beginning of their interview, demonstrated a preparedness to be highly reflective as the interview proceeded. Participants verified that their decisions to undertake cosmetic surgery were not random acts occurring in isolation from other events. Rather, they contextualised the circumstances which informed their decisions to have cosmetic surgery by locating them within a continuum of logic, incorporating self and social experience. Following Schilder (1950), I have argued that body image is constructed through social interaction and participants in this study confirmed this viewpoint. Their interactions with significant others figured prominently in their accounts of body image construction in the lead up to cosmetic surgery. Continuing with the broader theme of shame and its implication in body image construction, this chapter examines the social contexts which participants elaborated as heightening their body image concern. It draws from the interviews to explore the concerns the participants themselves described with a view to uncovering the way in which shame is implicated in the enactment of cosmetic surgery. Previous chapters have considered the role that families play in the early socialisation and development of body image. This chapter shifts the discussion from early childhood to the way in which other interactions might affect body image. It moves from childhood to adult relationships by considering how partners influence body image. A second section considers how the participants' integrated post-surgical embodiment into their own self-stories and social lives. A third section examines the role which cosmetic surgeons play in reconstructing preferred body image, and a final section draws from participant accounts to explore how the constraints of the modern workplace impact on body image construction.

Shame, body image and identity in the aftermath of loss

Lillian's account in the previous chapter touched on the role partners might play in the construction of body image. The role of partners is contentious. It is often assumed that both subtle and overt criticisms by men of their partner's appearance, or even more subtle, their voiced admiration of women viewed in media forms, needles the insecurities which women feel about their body image. In agreement with Davis' (1995) and Gimlin's (2002) findings, this study found no evidence to suggest that men consistently criticise women about their appearance and drive them to have cosmetic surgery, although three women did report the eroding effects of such criticism. The majority of women who were partnered at the time they underwent cosmetic surgery spoke of having partners who supported them in proceeding with surgery 'if that's what they really wanted and it would make them happy.' In these accounts the motivation and planning for surgery was initiated by the woman herself and the level of enthusiasm their partners then invested in the process varied. Some became very involved while others remained passively engaged. A small number of women recalled their partner's alarm at their planned surgeries, since they believed that their partner's appearance did not need altering and any surgery posed unnecessary risk. They did, however, concede that proceeding with surgery was ultimately their partner's choice.

Significantly, the most prevalent theme relating to partners overall was the impact of marriage breakdown or separation on body image. In Australia, between 32% and 46% of all marriages will end in divorce within 8.3 years (de Vaus 2004:46). The phenomenon of women seeking cosmetic surgery to salvage a failing marriage, or in the aftermath of a failed marriage, is well known to cosmetic surgeons, and the practitioners I encountered were familiar with this type of client. Over one third of participants (11/28) had cosmetic surgery within five years of a marriage breakup or separation. Of this group the majority (9/28) also identified long term body image issues which developed in childhood or adolescence. For many women separation initiated a period of introspection and re-evaluation in which the structures that facilitate the potential for self-improvement were actively sought. Many changed jobs or resumed education to advance their social capital in the face of changed economic conditions. Cosmetic surgery was sought to improve both poor body image and the potential for employment, but it was also undertaken as a strategy for rehabilitating the

fractured self in the aftermath of loss. Not only did it provide structure in the form of transformative ritual, it facilitated the ordering and managing of emotions. Improving body image was seen to be synonymous with improving self-esteem, something a participant did to 'feel better about themselves.' Such phrasing suggests that there is a therapeutic dimension to undertaking cosmetic surgery, that it is an act of amendment, a salve for the wounded self.

Participants who had divorced or separated described a process of privatising body image by withdrawing and directing attention to its restoration. Others, having left domineering husbands, characterised surgical enhancement as an act of defiance, as a way of retrieving control and ownership of their bodies. In these accounts cosmetic surgery became a process of purging, cleansing and reinscribing the body by reinstating its boundaries under terms the woman and her surgeon agreed upon. Restorative healing follows any surgery. It is a period in which the body withdraws and requires specialised care, dressing and anointing. Some participants had photos taken in the post-surgery phase to show me. Their faces appeared battered and swollen with eyes reduced to slits. Others described their bodies as blackened by bruising, but most denied any post-surgical pain or downplayed it as an unavoidable part of the process. Surgical wounding anchors the body's materiality and emphasises its capacity to recover from trauma, but so much more than the body's ability to recuperate is invested in this restorative process. Hope for an improved self is conflated with the body's transformation. An integral part of the ritualised process of cosmetic surgery is healing and caring for a body which had previously been despised. It involves withdrawal and specialised grooming to facilitate the body's re-emergence as a social object, one now cleansed, enhanced and transformed.

Anthropologists van Gennep and Turner (in Turner 1977: 94) describe *rites de passage* as 'rites which accompany every change of place, state, social position and age' which are marked by three specific phases: separation, transition, and incorporation. Van Gennep viewed such rituals as the accompaniment of transformations in social status, but Turner extended the meaning to encompass ritual of almost all types (Turner 1982:24). Whilst this model originated from observing the formalised ritual of tribal groups, its formulation parallels the self-initiated ritual described by those who took part in this study. Separation

occurs when the shamed self imposes exile upon itself. In rehearsal it re-examines, re-evaluates and re-imagines how it might look if it undertakes cosmetic surgery. The liminal or transitional phase (Turner 1977:95) corresponds to the period of surgery. Under anaesthesia the body enters a death-like state, it is wrapped in special clothes or bared and its social status reduced to that of 'faulty body' as it is surgically refashioned to negotiate new life. The liminal phase merges into a healing phase before the final phase of incorporation when the embodied self returns to her social life which, the best outcomes report, is accompanied by compliments and the approval of others. Cosmetic surgery presents a perfectly tailored, institutionally sanctioned and ritualised adjunct to the transformative process which the contemporary experience of loss initiates, and indeed appears to insist upon. Moreover, it restores and enhances the status of the shamed subject.

The most poignant accounts of relationship breakdown came from a small group (4/28) where separation had been complicated by the infidelity of a partner. These participants reported the most crushing effects on body image and self-perception. For these women, body image had always been a fragile construction but being rejected in adulthood and subsequently replaced by someone who was perceived to be better looking served to confirm and reignite old patterns of perceived shame which had originated in formative experience. Being rejected by a partner re-aroused the spectre of faulty body image and brought it to the fore in heightened focus. All from this group spoke of an initial period of depression immediately following separation. According to Lewis (1971), these symptoms unequivocally reveal the presence of shame. In depression body image and self-esteem conflate in physiological and social withdrawal. For women who had been left under such effacing circumstances, repatriating the self began with enhancing body image.

If we refer back to Freud's (1957) discussion of narcissism the period of withdrawal and depression in the aftermath of separation could be described as narcissistic. It is a period characterised by introspection and emotional turmoil which invigorates the self-preservation that Freud associated with narcissism. Narcissism is the self's antidote to shame. Shame is engendered when the self is rejected as a libidinal object. By engaging narcissistic investment in the self through the medium of body image the self is able to sublimate and

transform shame. Cosmetic surgery proposes a creative agenda: it seduces and appropriates a shameful body image, and purifies and transforms it into something more acceptable to the self. Narcissism is integral to the process because without dedicated self-focus the transformative agenda could not ensue. That body image should be the focus towards which narcissism is directed is not at all surprising. His own reflected image is what the Greek youth Narcissus confuses, and more will be said about this in the following chapter. Body image is fused to self-image and infuses the self's perception of its social identity. Cosmetic surgery persuades with intimations that it can ameliorate body image and transform the body into something the self can love. Rather than narcissistic, cosmetic surgery appeals to the injuries of narcissism, to shame. Moreover, the body and body image itself were identified by many in this study as the final bastion over which control could be enacted, particularly when everything else external to the self appeared beyond control.

Sarah

Sarah was another participant who had cosmetic surgery in the aftermath of separation. She presented as an articulate, well-educated woman in her thirties who worked in the education sector. She had weight-loss surgery initially, followed by abdominoplasty and a breast lift three years before we spoke. Her husband had not left her for another woman but had committed suicide. His death followed a period of escalating mental instability and domestic violence. Sarah was left with no option but to take out a restraining order against him which left her and their three small children holed up in a house with bars barricading the windows and in fear of their lives. It was a situation Sarah described as 'dire' and she was in no doubt that her husband would have killed them if he had not killed himself. Throughout his decline and in the two years following his death Sarah and her children traversed profound and complex grief. During that time Sarah described her weight as going 'up and down depending on her stress,' but eventually her accumulated weight impacted her health and became unendurable. Sarah found that she had to address her body both functionally and aesthetically before she could move on from the situation.

I think after experiencing something like this you get a different perspective on where you're going and how you want to get there, who you want to take with you and what you want to be at

the end of it ... There are things I want to do with my life and things the children need to do with theirs. And I'm sure we can do all of it. It's just a matter of managing it. And, weight was a problem for me because at that time I wasn't able to do what I wanted to do because I wasn't healthy enough to do it. I couldn't breathe properly. I had high blood pressure. I felt *foul* about myself and the way I looked. It wasn't the way I wanted to be perceived by people, or the way I wanted to see myself. *It wasn't me. I didn't like it. And I couldn't get out of it.* And the gastric band was, a way of, of helping me towards those goals (Sarah, original emphasis).

It was a period in which Sarah had to re-evaluate her life. Her initial comments reveal an acute paring down to the most important of her responsibilities, to what she must do for herself and for her children to move on from this episode. They too had been deeply traumatised, their lives ripped apart. They have endured unimaginable horror. It took Sarah two years 'to get them to a point where they were just not flying around the place like mad things.' Their lives needed order and so did she. Sarah was deeply irritated by the physical manifestations of the weight she had accumulated. Like the bars on her house, her body had become something intolerable that trapped and constrained her, something she could not 'get out of.' It was a barrier to moving forward from the rupture that preceded it. For Sarah, recuperation began by focusing on her health, her body, on what she could control. Body loathing and self-loathing conflate in her description of the 'foulness' she attributed to herself and the way she looked and felt. She described herself at the periphery of shame, as abject. Her recovery followed an embodied trajectory and her use of surgery was both therapeutic and pragmatic. It provided an emancipatory framework from which she was then able to establish the order required to amend her self-conception. She saw surgical intervention as a prerequisite to engineering the other transformations required in her life. Sarah's account is extraordinary and shocking. She too had been deeply wounded and her engagement with surgery emphasised themes of cleansing, healing and reconstructing the self through the amelioration of her body and body image. Sarah's account might be viewed as emerging from an extreme set of circumstances, but there was another woman whose circumstances combined a partner's suicide with cosmetic surgery who took part in this study. She, like Sarah, engaged cosmetic surgery pragmatically and therapeutically as a means to reinstate her sense of self and redefine her boundaries in the aftermath of loss.

Ava

Lewis (1971: 86) observes that shame disturbs identity, and Sarah's account underscores the unravelling of identity which might occur as a consequence of violent separation. When interviewed, Ava was in her early sixties and had undergone a facelift and numerous other facial modifications. After a long and seemingly successful marriage spanning nearly forty years Ava's husband had an affair with a younger woman. Ava had no warning of her husband's infidelity and the effect was devastating. She slumped into a period of deep depression which lasted almost two years during which she contemplated suicide:

I was alone for the first time, facing a whole new future that was uncertain and I didn't know what my life was going to be. Or what my purpose in life was. Or *who I was*. I didn't know who I was, because I'd always had this identity, and suddenly I lost the identity that I'd had all those years. I had to find out who I was ... Suddenly I had time on my hands. People used to say, "Now it's your turn, do something for you." And I thought (short exhalation); "I don't know what to do for me." I was always thinking of other people. It was my husband and his needs, my children, their needs, and so on. And I realised that if I could have this done with my face it would be a whole new start for me, in a way, with my whole new life (Ava, original emphasis).

Ava spoke very softly in a voice full of emotion as she recalled the dark days following her separation. She was well aware of their significance but preferred to be optimistic rather than dwell on those events. Much of her interview focused on the positive sense of self cosmetic surgery had afforded her. Ava had remained single but enjoyed an active social life. Being well received by others clearly appeared to be important to her. Ava recalled she had always been particular about her appearance. As a teenager she spent hours applying make-up to mask the acne she described as 'abhorrent.' She had her first cosmetic surgery when she was in her thirties, but up until her separation had not considered any further intervention. Remodelling her appearance was a significant feature of her post-divorce recovery. Numerous facial surgeries, the number of which she was no longer sure, made her one of the most prolific consumers of cosmetic surgery to take part in this study. In addition, she was one of only two participants to use credit to pay for surgery and was adamant she would be seeking further modification. Ava's continued use of surgery was portrayed as in keeping

with her philosophy of dedicated self-improvement. She described a highly ritualised medication regime consisting of numerous supplements and anti-oxidants taken at optimum times of the day. She regularly attended exercise classes. Hair and make-up were given committed attention. Ava was adamant that she wanted to look good for herself, but it was also apparent that she derived considerable pleasure from the positive impressions she made on others. Her surgical ventures, however, were closely guarded secrets. Being known to be surgically enhanced was not how she wished to present. Ava morphed seamlessly and unapologetically into a more youthful version of herself. She said, with an air of drama, 'this me, this is who I am' (Ava). Any exposure of her surgeries would be deeply shameful.

The first overt shame which both Ava and Sarah encountered was the 'exposure of private details' (Gottschalk in Lewis 1971:51) regarding their failed marriages and it was these indecorous changes in their personal circumstances that were socially shaming. By association they were implicated in the actions of their husbands. Shame, it will be remembered, has the capacity to leak and taint others who are meshed in its presence. Shame is also implicated in the disappointments of love and sex (Lewis 1971:85). Sarah's stress-related eating and Ava's contemplation of suicide in the aftermath of their losses suggest subsequent self-loathing and self-directed hostility. Both women experienced their changed circumstances as something beyond their control and therefore incurred from a position of passivity which was also deeply mortifying and unequivocally shaming. For these women cosmetic surgery provided a structure that was meaningful, in both a ritualistic and material sense, through which they were able to re-establish themselves and their physical boundaries as redefined and detached from their partners. Shame is characterised by the permeability of the self's boundaries (Lewis 1971:32) and reinforcing one's boundaries to establish the self as contained and independent is typical of amending shame. Cosmetic surgery provided an opportunity to redress the self, to restore its dignity and social status through the literal restoration of the body's boundaries.

While Ava's separation and subsequent encounters with cosmetic surgery did share similarities with others already discussed, there were important differences. Her husband's infidelity shattered the collaborative identity which their marriage had represented and she

was clearly rocked by the fact and form of its demise. Like others in this study, her first engagement with cosmetic surgery following her separation was expressed in terms of therapy, as a route to recovering and reclaiming her identity, but her more recent surgeries were something different: they were initiated as technologies of self-improvement. Shame, however, still motivated her actions, this time as a contingency to ward off the potential shame associated with ageing. Ava viewed the aged as ignored, patronised and relegated to the margins of social life. She described her own life as socially active with a diverse range of friends, and the maintenance of her social status appeared to be closely related to looking as attractive and youthful as she could. Ava was not alone in her pessimistic view of ageing, nor was she the only participant to change the way in which she used cosmetic surgery. What had begun as rebuilding a new identity, 'a new face for her new life' (Ava), had shifted, with many subsequent enhancements, towards a technological mode of using cosmetic surgery. I will return to this discussion below. For now I wish to explore other manifestations of shame observed in this study implicating body image and cosmetic surgery. In these instances shame is emphasised in the concealment of cosmetic surgery. Here participants remained firmly committed to a particular form of impression management which celebrated an improvement in body image, and one presumes a positive alteration in appearance, while guarding the secrecy of surgical intervention.

Cosmetic surgery, secrecy and shame

Angela

Whilst the preceding accounts provide overt examples of what I have called shame, other participants were more subtle in their enunciations of shame. Angela's account of breast augmentation provides an example. Angela was as a poised and confident young woman in her late twenties who had recently undertaken breast augmentation. Hers was one of the most carefully articulated accounts presented for this study. Angela argued against any suggestion that she may have disliked her pre-surgical body. Rather, she carefully clarified, she 'would have liked things to have been different.' Her smaller breasts made her feel 'inadequate' and the 'pear shape' of her body 'didn't make [her] feel very good about [herself]' (Angela). Angela went to considerable lengths to manipulate the image her pre-augmented body projected. She used specialist undergarments including a water bra,

complete with a fluid filled pocket, to enhance the impression of her breast size, but over time she found them ‘cumbersome’ and was never entirely relaxed wearing them, particularly when in public and wearing fitted clothes. Angela spent many years rehearsing her altered body image with underwear props before she incorporated what had literally been an external prototype of an implant into her body. Despite the recentness of her surgery she had psychologically amalgamated breast implants with such ease that she claimed ‘they feel very natural, like I should have been born with them’ (Angela).

Angela was also highly pragmatic in the way in which she engaged cosmetic surgery as a readily available technology to improve her appearance and at one point in the interview described her surgery as an ‘indulgence.’ In many ways her attitude reflected her youth and coming of age in a cultural climate which has come to view cosmetic surgery as an increasingly commonplace grooming option. Angela did however, have concerns about how others would react to her having surgery:

There is a lot of stigma attached to having breast implants. None of my family knows, very few of my friends know. So, initially I had to get through that, that public perception, or the general perception that cosmetic surgery is ridiculous. Or its, well, it’s not seen as the right thing to do. A lot of people see it as “Oh, what do you want to go doing that for? You’re beautiful as you are.” It wasn’t about not being beautiful, it was more, I have an opportunity to ah, change the way I look, and make *me* feel better about how *I* look (Angela, original emphasis).

Angela lived in a small regional town but opted to have her surgery at a private hospital interstate during her annual leave so that she had time to recover before she returned to work. Her surgeon was selected for his reputation as a breast enhancement specialist but confidentiality has also been an important consideration. Angela lowered her voice and spoke quietly when she described her surgery as ‘a very private thing,’ adding that ‘the idea of someone judging me for it is really upsetting’ (Angela). Angela articulated the least emphatic pre-surgical body loathing observed in this study. She readily conceded that she would rather have had bigger breasts but was adamant that her overall body image was good. Yet it was also apparent that she was not immune from experiencing something close to shame with regard to her pre-surgical body image, which was evidenced by the attention she

gave to hiding the smallness of her breasts. However, Angela's most overt expression of shame was her fear of others knowing she had undergone cosmetic surgery. She was well aware that others might view her actions as 'ridiculous.' In Angela's account, shame was compounded because the initial shame she directed towards her breasts had been overlain with the shame of having surgery.

Angela's declaration of how 'natural' her implants felt also illuminates the transformative process of cosmetic surgery. In being changed physically by surgery, Angela's most significant change was to her body image. She was no longer plagued by self-consciousness and part of that transformative shift may mean that any serious shame-inflected sentiments that were felt in the pre-surgical period were no longer valid. A tendency to minimise pre-surgical body image shame appeared more prevalent in the accounts of those who were the most committed to keeping their surgery secret. They, like Angela, hoped to morph into their surgically enhanced bodies without any difference being registered by those who had known them all their lives. Angela's extended period of rehearsing bigger breasts with undergarments probably aided her success, but she was also aware that the settings in which she displayed her re-contoured body needed assiduous monitoring. Despite feeling 'natural' in her newly enhanced form, the spectre of shame persisted in the discovery that she was concerned enough about her body image in the first place to have sought surgical amendment.

Shame faced

Secrecy around cosmetic surgery was a dilemma, most significantly, for women who had undergone facial surgery. In these instances the intention was to have a perceived anomaly, or evidence of ageing, surgically corrected and then to appear before family, friends and colleagues looking 'improved,' 'rejuvenated' and 'refreshed' without surgical intervention being suspected. Such intentional subterfuge might easily be interpreted as a form of deception, but participants carefully deflected any such suggestion by defending their sovereignty in making self-orientated decisions which they felt they have every right to make. Participants repeated declarations it was none of anyone else's business what they decided to do with their own bodies. The oft-repeated claim 'I had surgery for myself' sought to reinforce the bounded notion of the self as a separate and contained entity, but such claims

inevitably run counter to the social aspects underpinning any grooming practice and, in the case of facial surgery, the very success or failure of the intervention was qualified in the feedback received from others. Being appraised as 'looking well' was the most highly-prized compliment the newly facelifted patient sought. Proponents of cosmetic surgery defend its use as a private enactment but its effects are measured in the reflected gaze of the social world, and because of this, cosmetic surgery can never be contained to the private domain alone. Cosmetic surgery emphasises that the body is a social object to be displayed, admired and desired.

The period immediately following facial surgery is without doubt the most delicate period of social interaction. At this stage the surgical effect is tightest and most pronounced, and friends, family and colleagues must be encountered for the first time. Patricia was interviewed in the weeks after surgery and just days before she intended returning to work. She had not informed her colleagues that she was having a facelift while she was on leave and her anxiety about how her appearance might be received was foremost in her thoughts. It was a theme that she returned to throughout her interview. She did, by her own account, look very different and the conspicuous yellow shadows of receding bruising were still visible through her make-up. Patricia, it will be recalled, held a senior position in a public company and her fragile confidence seemed at odds with the authority which her position entailed. Furthermore, she reiterated her contempt for dishonesty on a number of occasions throughout the interview. Reconciling her own moral code and the way she would manage the obvious change to her appearance presented her with an ethical conundrum:

I either should have said to them (her colleagues), I am going to be away for three weeks because I'm going to have a facelift and be completely open with everybody. That would have probably been the best way to go. And I may even have to resort to the truth anyhow. But I'm concerned people will whisper. Whisper: "what's different about her?" "Oh, I think she has had a facelift." That's the bit, either they can't know, or I tell them; because I don't want to pretend and be caught out ... I just don't want to be caught in a lie (Patricia).

Patricia articulated aloud the reflective processes she was rehearsing in preparation for returning to work. Temporally, she projected an imagined scenario where she was compelled

to explain the difference in her appearance. Patricia's most excruciating shame was not that she had a facelift but the possibility that she might be perceived as dishonest. The tension between truth and deception and the concerns Patricia had about being able to 'pass' (Gilman 1999) with her surgery unnoticed were undoubtedly captured because of the timing of our interview, but those first occasions of social re-engagement following facial surgery were retold in other interviews where facial surgery had been performed and the participant had been particularly concerned to keep the matter confidential. Surgeons often advise their patients to change their hairstyle before they are about to meet people whom they regularly encounter for the first time after facial surgery. Then, when friends and acquaintances begin to puzzle over what is different in the newly lifted face, patients can deflect attention from their faces and agree that they have indeed changed their hair.

Receiving compliments about how well one looks in the post-operative period without actually admitting to surgical assistance requires a particular form of resolve. Ava also made a point of describing herself as someone who never told lies. She spoke of her moral qualities in a way which enabled her to differentiate herself from others. This appeared to be at odds with her commitment to maintaining the secrecy of her successive facial surgeries. However, she engaged a number of strategies which allowed her to maintain her own sense of moral integrity without believing that she was lying. She described how she managed meetings with acquaintances when she still had plaster across her nose following her second rhinoplasty:

I have very high standards in many things. Number one is morals and, um, honesty, integrity ... Now, I don't lie, that's another thing, I don't lie. So I wasn't going to lie (about having cosmetic surgery), but someone might say, "*Oh goodness what have you done to yourself!*" And I'd say something like, "Oh well, one of those things." Or, you know, just brush it off and change the subject (Ava, original emphasis).

In recalling several similar encounters Ava demonstrated well-honed skills in deflecting the suspicions of others in the aftermath of her many facial surgeries. Furthermore, she appeared to enjoy the challenge required in passing. She described having cosmetic surgery in distinctly playful terms, such as 'thrilling' and 'fun.' She delighted in whatever pleasing

compliments came her way from friends and acquaintances following her surgeries, but declined to offer further information. Part of her argument rationalised that technically she was not being deceptive in any way: rather, she was protecting herself from the jealousies of others. Like many participants, she viewed the ability to have cosmetic surgery as a form of status which would engender the envy of others. By invoking envy and casting it in opposition to her own character she was able to construct a self-affirming argument which verified that her interests were best served by keeping her many facial surgeries to herself and a few trusted confidantes. When I asked why she was so guarded about her cosmetic surgeries she replied:

I feel others would judge me ... I do, yes. It's very personal. Some people may want it (cosmetic surgery) and can't afford it. Some people may want it, but are frightened of it, maybe they have fear. Some people may be jealous of that. Because I know the human fragilities, jealousy is something I cannot myself feel. And I have often tried to imagine how you feel jealous because that's not one of my traits. But I can see it in other people, so I'm aware. I guard against that situation (Ava).

The secrecy surrounding Ava's surgeries was scrupulously guarded. Her surgeries were performed interstate and formed a clandestine stream running counter to the highly visible and respected social position she described holding within her community. Such meticulous care had been taken to keep these matters confidential and hidden that there can be little doubt that Ava would be mortified if the secrecy of her surgeries was breached.

In her study of women who had undergone cosmetic surgery in New York, sociologist Debra Gimlin (2000) observes that, in defending their decisions to have cosmetic surgery, her participants too constructed particular arguments which elevated their own moral characters. She briefly speculates that two of her participants may be ashamed of their decisions to have cosmetic surgery, but these ideas are not developed. Gimlin's central finding was that in defending their reasons for cosmetic surgery her participants struggled to reconcile the "inauthenticity" of their surgically enhanced bodies with a notion of selfhood. However, there is evidence in Gimlin's writing to suggest that her own attitudes may have influenced her research findings. She recalls interviewing a woman who had a facelift and contrasts her

dainty, ladylike appearance with her own 'bulky sweater and combat boots' (Gimlin 2000:83). Gimlin reflects that the discrepancies in their appearance make *her* feel self-conscious but she fails to countenance the possibility that the woman she is interviewing might also feel similarly self-conscious, and that may have contributed to the defensive account she gave. Later in the same work Gimlin (2000:94) writes, 'If women are attempting to use plastic surgery to recreate themselves - to make claims through the body about who they are - they must also deal with charges of shallowness.' Gimlin (2000:96) reiterates that her participants are not submissive 'cultural dopes,' but she does appear to veer close to positioning her interviewees as 'other' to herself. Cosmetic surgery is one tool among the myriad of strategies which women employ to address powerful anxieties experienced around the body and body image that many women appear to be increasingly affected by. A position of 'otherness' dismisses the importance and prevalence of such anxiety. The distancing mechanism of 'otherness' makes it easy to miss an underlying structure such as shame which, I contend, is an underpinning feature of the beauty system. Furthermore, shame engenders body image anxiety and encourages a technology like cosmetic surgery to flourish.

In the current study, defending one's surgeries appeared to be both contextually and temporally specific. It was only in the face of unwanted exposure, or when under threat, that participants described the need to be defensive. Moreover, participants themselves did not appear to experience their bodies as inauthentic: rather, they appeared to become, particularly over time, totally aligned with their surgically enhanced features. One woman who had a facelift commented that neither she, nor her friends, remembered how she used to look before she had extensive facial surgery three years before we speak. Initially they remarked how well she looked and nothing more was ever said. Like others in this study, this particular participant reported an easy integration of her post-surgical body image and welcomed the positive changes its effects inaugurated. She was, however, planning more interventions.

The first cut in "becoming surgical"

Over one third of participants in this study had undertaken more than one cosmetic surgery and the majority believed they would have more in the future. Always uncovered and on display, it appeared that there is no other area of the body more intensely scrutinised,

fragmented or more precisely mapped into areas which might be subjected to surgical intervention than the face. Even women who declared in one moment that they would never have more cosmetic surgery spoke in the next of surgically reviewing small, barely visible areas of scarring or puckered, remnant, unwanted evidence of previous surgeries. Perhaps it is the ubiquity of mirrors, as Weldon believes (cover of Blum 2003), and the relative exposure of the face that makes it so readily the subject of critique and surveillance. Or perhaps it is the infinitely illusive promise of cosmetic surgery's seductive potential and the underlying failure we all share in falling short of the cultural ideals to which it appeals.

As was suggested earlier, there appeared to be a marked difference in the way that the initial and subsequent surgeries were discussed. Like Karen in a previous chapter, other women too spoke of wanting to be totally satisfied with their surgeries. The first surgery was a huge step, carefully considered and researched, and not entered into lightly. Evaluating the self as in some way flawed or unacceptable, withdrawing from social life and feeling unworthy of love all suggest that shame is implicated to varying degrees in the motivations of those who initially seek cosmetic surgery. However, the motivation to engage subsequent surgeries belongs to another narrative stream which has as its driver self-improvement: making the most of the resources available to the self and fulfilling the promise of cosmetic surgery's infinite potential. By embracing cosmetic surgery, Victoria Blum (2003) argues, patients are changed in particular and significant ways. She suggests that having the first cosmetic surgery initiates neophyte exponents to ongoing and compulsive surgical management of their appearances. She nominates the initial surgery as definitive: 'becoming surgical is the cornerstone of the contemporary experience of cosmetic surgery' (Blum 2003:274). Her own research into the phenomenal rise of cosmetic surgery in America is extensive and affords her some certainty in claiming that cosmetic surgery is potentially an addictive behaviour. Patients may be moderate in spacing their surgeries, seeking a procedure every five years or so, or they may return to their surgeon every few years. Either way, once the first cosmetic surgery has been undertaken the likelihood of returning for more is almost guaranteed (Blum 2000). There is evidence of Blum's claim in my own participant accounts. Embracing the first cosmetic surgery was normalising, seductive and, as one participant below observed,

potentially addictive. Allie was keenly aware that in being surgically transformed she was also transformed in the ways in which she then imagined her future body image:

You read about it in magazines, where people write about cosmetic surgery being addictive, like the strange woman who has had the cat thing done to her face. Having had cosmetic surgery once, I can now understand the addictive qualities of it, because having surgery has made such a dramatic difference to me. At the end of the day it hasn't turned me into Catherine Zeta-Jones but the effect it has had on me, mentally and physically, has been so pleasing. The end result has been what I expected and I could certainly contemplate other things. I'd like to have the boobs lifted and I wouldn't mind a touch of the chin being gone. They are things I am going to live with, but it's in the back of my mind, I could have those things done. (She quickly adds) But I doubt very much that I would (Allie).

Later in the interview she returned to the same theme:

If the cost wasn't prohibitive and I did lose weight, I would love to go into my doctor and say, "My body is a blank palate, what would you do to it?" And see what he says. This goes back to the fantasy of what you can have done now and the addictive quality of it. But whether or not I would ever do that, I really don't know (Allie).

Allie let her first transformative flight of fantasy take off before she reeled it in with doubt that she could really have any more surgery done. By the end of her second fantasy she was less sure of her resolve to resist the seduction of transformation which future cosmetic surgery might offer. For now the inherent cost appeared to be her only real brake.

Just over one third of participants taking part in this study had facial surgery and it was this group who appeared the most ready to consider further surgery. One major surgical event frequently includes a series of smaller procedures and it is significant to note that many participants initially consulted their surgeons with one procedure in mind, but were convinced by them to have additional procedures. An acquaintance recalled consulting a cosmetic surgeon for an abdominoplasty after separating from her husband. The surgeon suggested that if she had a breast lift done at the same time he would be able to write off the

cost through Medicare with only a slight increase in her out-of-pocket expense. She found his offer ethically dubious and declined treatment. Victoria Pitts-Taylor (2007) also discusses the greyness of this ethical area when negotiating her own rhinoplasty following a skiing accident.

The questionable ethics of surgeons who recommend additional surgeries to their patients is broached by Blum (2003:278). This subject is intensely clouded. Participants appeared to accept their surgeons recommending additional procedures, particularly when any suggestion was framed around achieving an optimum result. As one veteran of many facial surgeries commented, 'In the end it was the overall result that counted. I wasn't going to care what he did. He was the expert, and I put myself in the expert's hands. And I knew he was, in my opinion, the best in Australia' (Ava). Additional procedures also meant additional costs which constituted added stressors for women who had budgeted carefully for their surgeries. Two women who spoke of financial difficulty in meeting payment for the additional procedures suggested by their surgeons spoke of an elevation in anxiety in the post-operative period. Both women reported post-operative complications including localised infection at the site of surgery.

Many facial surgeries required surprisingly long anaesthesia. Participants estimated their facelifts took between four and eight hours, particularly when a number of procedures were done at one time. Additional time exposes tissue to airborne micro-organisms and increases the risk of post-surgical complication, of which infection is the most significant. One participant whose facial surgery took a staggering eight hours incurred both a pressure sore on her sacrum and a serious post-operative infection which required rehospitalisation and drainage under general anaesthesia. Pressure sores occur almost exclusively in those who are bedridden when the pressure of bony prominence on a mattress reduces the blood circulation required to sustain healthy tissue. Participants who had cosmetic surgery, along with the pain and bruising, also tended to minimise its associated risks. A number of other post-operative complications were noted by participants relating mostly to the loss of sensation at the site of surgery. Five participants also reported post-operative infection; but overall, most were generally satisfied with their surgeries and few were deterred from the prospect of more in

the future, thus adding veracity to Blum's (2003) claim that cosmetic surgery is potentially addictive.

Body image, shame and surgery

Under the authority of medicine, cosmetic surgeons themselves surgically delineate the boundaries of female shame. Surgeries to "correct" what once might have been considered "normal," manipulate, hide and efface temporal effects upon physiology and reduce variance at its parameters. Advances in medical technology and a reduction in the cost of procedures have been integral to the ascendancy of cosmetic surgery but, perhaps even more significantly, its alliance with the corporeal ideals propagated in the fashion and visual media industries conspire to unsettle women and increase the dissatisfaction they feel towards their bodies. These industries serve cosmetic surgery by disseminating its aesthetic values and normalising its enactments.

Cosmetic surgeons, as frontline emissaries of cosmetic surgery culture, actively re-define and constrain the body images of women by devaluing ageing, evidence of maternity and diversity in physiology, in line with the broader ideals their industry seeks to promote. Cosmetic surgery almost always refashions the body towards that of a younger woman whose body more closely approximates a woman of early reproductive age. The lines of the mature face are erased, the contours of the body elevated, evacuated and smoothed and breasts, whether enlarged or reduced, are surgically aligned to those of a youthful woman, pert and upright. Cosmetic surgery eroticises what it defines as abject. In privileging sexualised forms of womanhood cosmetic surgeons endorse the central tenets of the beauty myth (Wolf 1991) and valorise biological reductionisms which debase both men and women by reducing the elements of attraction to notions of sexual desire.

The participants' description of their encounters with their surgeons varied, but in several accounts it was clear the surgeons involved had specific aesthetic agendas and used particular narrative forms in their interactions with participants. One participant presenting for a facelift recalled being asked by her surgeon if she wanted to look like a celebrity: 'He asked me if I wanted to be a Hollywood star. He was saying that he could make me look like a

Hollywood star' (Jenna). Jenna responded with humour, saying Hollywood would not be able to afford her, that she did not need to be a 'glamour girl,' she just wanted to look 'tidier' or, to use the term she frequently used throughout her interview, she just wanted to 'look like a well-kept woman.' If all women are abject as Kristeva (1982) suggests, then none are more so than those who are obviously unkempt. It will be recalled from a previous chapter that Jenna had endured incest as a child and had had many cosmetic surgeries which she herself had come to question as a form of 'self-mutilation.' However, in the consultation for her most recent surgery both she and her cosmetic surgeon skated across the surface, neither ventured into the murky waters of her damaged psyche. Their exchange perpetuated the illusive promise of transformative potential and he charmed her by suggesting he can transform her into something special. Both stayed on the surface. It is routine for medical practitioners to record their patients' medical and surgical histories, but he did not delve into her history which suggests he was not interested in what he might find there. He appeared to stay with what he knew: that she had potential and his intervention would produce a pleasing result. He contained his intervention to craft, to that of an artisan specialising in working on the surface, re-contouring the lines of the body and manipulating skin. Psychic injury is the domain of another medical discipline and the differentiation of medicine into precisely bounded sub-specialties protected and absolved him of any requirement or responsibility to enquire into the more complex reasons behind Jenna re-presenting for cosmetic surgery yet again. Cosmetic surgeons themselves are well aware that the reasons for women to present for cosmetic surgery can be complex, but how far they feel they need to explore those reasons can vary greatly. Jenna's surgeon stayed at the surface, a surgical dream spinner: 'I can make you beautiful, as beautiful as a Hollywood star.' He re-echoed what those who are narcissistically injured long to hear: "You will be beautiful and worthy of love." Another participant recalled anxiously waiting to be wheeled into the operating theatre when her surgeon approached her and said: 'Don't worry, you'll just go to sleep and I will make you beautiful' (Tanya). She was nervous and he reassured her that she was making the right decision, he would make her beautiful and she was in safe and caring hands.

My reaction to hearing these reported exchanges was very different from the women who described them. They were flattered, touched and felt special, whereas I was taken aback by

the blatant use of sycophancy under the guise of professionalism. I found myself questioning whether these were merely innocuous, if somewhat cheesy, lines enlisted by unimaginative surgeons to put their patients at ease, part of their patter which is pulled from a repertoire of compliments routinely dispensed during the course of the day to patients they gauged would respond positively. Or were they part of the way in which cosmetic surgeons actively create, recreate and reinvest in their own positions of mastery, a benevolent form of paternalism? Many participants appeared to be in awe of the skills of their surgeons. Tanya commented on her surgeon's reconstructive work: 'My surgeon does some fantastic things for people, like little kids with cleft lips ... He's like god. He's just amazing.' The field of reconstructive surgery moves close to cosmetic surgery when psychological justifications for surgery are mounted (Haiken 1999), but few surgeons appeared interested in the reasons behind participants in this study presenting for surgery. Within the consultation process the cosmetic surgeon is, at the very least, required to assess whether an aspect of a presenting client's appearance requires, or can be surgically amended. However, the dialogue of the surgeons above goes beyond such an exchange. In proposing that they can transform their clients into something dazzling and beautiful these surgeons appear also to be investing in their own myth-making. Their comments suggest that they actively construct their own heroic self-conceptions as producers of the transformative arc in which cosmetic surgery positions itself. The narrative forms they mobilise follow the archetypal fairytale structure in which most women in the Western world have been well schooled. Typically, a poor female protagonist falls into a deep sleep. Her future is uncertain, but that all changes when she is awakened and transformed by the intervention of a powerful saviour: ugly duckling or sleeping beauty to beautiful princess with the aid of heroic surgeon. He is like a god, transforming plain to beautiful, ordinary to celebrity, unacceptable to socially acceptable; shame to pride is the transformative trajectory in which cosmetic surgery is located and to which the surgeons above elude.

In carving out their specialist niche cosmetic surgeons uphold and promulgate particular aesthetic values and agendas. This is most evident when surgeons themselves suggest additional procedures beyond what a patient initially requests. Two participants recalled such encounters with their surgeons:

Julia: My GP referred me to see the surgeon because I had problems with my nose and my vision. I had difficulties breathing and hooded eyelids. But it was later that the surgeon said, "Well, normally if we do eyelid surgery we do an eyebrow lift as well" ... I'd never heard of that. He gave me information sheets. And I went away, had a look at those and thought, "Oh my God, this sounds ghastly. I'm not sure whether I will go through with it."

Jane: So you went in (to the consultation) knowing you would have your nose done, and your eyelids, and he suggested...

Julia: I didn't know he would do the bottom of the eyes. I didn't know anything about that. Having cosmetic surgery started off as a medical thing. And I went in for that reason, because I needed to have something done for my vision and my breathing ... Had I not had those medical problems, I would never have considered having cosmetic surgery ... I wouldn't have had it done.

Lynne: I have always had a thing about my turkey-gobbler neck. I hated it, absolutely hated it. When I had photos taken I would always sit in a way so it wouldn't show. I was paranoid about my neck. And I always vowed I would have it done when I could afford it. I was actually just going to have the neck done and then the surgeon said, "Well really, you should have it all done (a full facelift)." He sort of persuaded me that that was the best way to go. And yeah, I'm happy.

Another woman recalled that she and her surgeon had agreed upon the size of implant to be used in her breast augmentation before surgery. However, just before the surgery the surgeon said he would insert the implant they had agreed upon, but might proceed to a larger one if he thought it looked closer to the effect that he thought she was hoping to achieve. His interpretation of her desired result was based upon the pictures of women with breast implants taken from men's magazines that he had asked her to bring in to her consultations. She was furious when she awoke from anaesthesia to find he had inserted the bigger implant. Within a few days she had accepted his intervention and, like Julia and Lynne, was happy with the outcome of her surgery. Nonetheless, their experiences expose the surgeon as the final arbiter of how they should appear.

While the suggestion of additional procedures by the surgeon is complicated by the question of ethics, the majority of participants viewed the aesthetic opinions of their surgeons as a component of the specialisation they offer. One woman joked that it was more important to

her surgeon than it was to her that her breast appeared as natural as possible following her breast reconstruction. Another commented that she would definitely be having more facial surgery because her surgeon was not completely happy with his own work and *he* believed that more surgery was needed to achieve an optimum result. Several others considered their surgeons to be artists rather than technicians and, like Allie above, their bodies and faces canvases upon which the surgeon's creative skill was enacted. Some surgeons actively cultivate such impressions by displaying their own works of art in their surgeries and on the internet as evidence of their creative capacity. Such displays actively nourish the impression that cosmetic surgery is an artistic pursuit and deflects from the way in which it inadvertently regulates and defines the experience of embodiment for a growing number of women.

Three participants found the initial consultation with a cosmetic surgeon a decidedly uncomfortable affair. On each occasion the surgeon was remote and did not engage with them. One woman from this group, Amanda, gave a richly detailed account of her experience. Amanda, it will be recalled from a previous chapter, sought abdominoplasty after an extreme loss of weight. She had wrestled with the notion that she needed to have cosmetic surgery and as we spoke she struggled to explain why. Finally, she said 'It reminded me again of being really fat. I hadn't got rid of being fat. I was still left somehow with being fat. I was left with still being shamed' (Amanda). Amanda described her first consultation with a cosmetic surgeon as an encounter which exacerbated her feelings of shame. When I asked if it was the appearance of her body, or exposure to a stranger that made her feel shame she replied at length:

Um, probably both, and showing myself to a stranger who had not known me before. So I just looked like some kind of defective person. I felt like I had to explain my situation, to justify myself and I felt some kind of shame about that I think. And he really did not go out of his way to make me feel at ease. It was clearly business to him. I felt like I was in a sausage factory. His office was very glamorous, but I felt really odd the whole time I was there - made worse by the fact that I don't think he gave me any kind of eye contact the whole time I was there. He basically gave me a catalogue (of photographs of his work) and asked me what I wanted to have done? He then looked at the photographs I had chosen and said, "Oh yes, this, this and this." And then he said, "Yes I can do that, this is how much it will cost and this is how long it will

take.” Then he said, “Now can you stand over there, I am going to take some photos.” No, “Would you mind standing up so I can have a look” or, “you might find this embarrassing, but I need to have a look.” It was just: “Stand over there and I will take some photos of you” ... I hadn’t completely undressed, I’d just bared my abdominal region, and he wanted to take a side photo too, so he did ... This was before we had even agreed on anything. It was like a quote. He was doing a quote on the job to be done ... I felt traumatised by it, really quite traumatised. After he had taken the photos he then went back to his desk and started writing. So I redressed and he kept writing. Then he handed me the piece of paper, really without even looking at me again. He was quite dismissive. There was no social contact. There was no, “How are you feeling about this, are you feeling nervous about this,” or “What led you to this?” It was, “Yes, I can do this job for you; take this piece of paper to my receptionist.” So I was dismissed from his room and told to go along to the next room with this piece of paper to where the receptionist was. She was an incredibly beautiful looking woman about my age, who had clearly had a lot of cosmetic surgery done. She wore a huge amount of make-up, beautiful clothing, beautiful jewellery. I found her entirely intimidating, but bizarre at the same time. And I found myself just looking at her and thinking, “Oh my god, you wrinkly, funny, sloppy, fatty me, sitting in front of this woman, handing over this piece of paper like a schoolgirl handing a note to the principle.” I found her quite alarming. And I felt like I was staring at her, but she couldn’t even look at me. I was just a grubby little (she pauses), not even a patient. There wasn’t even the respect that you are normally afforded as a patient. I was a body that was defective, that needed work, needed fixing. And she didn’t look at me either. She asked me when I wanted to make a booking at the hospital, at which point I said, “Look, I haven’t decided whether this is what I want to do yet. I need to consider this and think about it.” And she just plonked her pen down and said, “*Well, you’ll just have to ring us later then*” (Amanda mimics her clipped and irritated tone). She was so superior ... very disdainful and incredibly parental ... And so, I was dismissed from there as well. But I made an instant decision; I certainly did not want *that man* touching me (Amanda, original emphasis).

Amanda believed her embodied presence was so offensive to both the surgeon and his receptionist that they could barely address her. They averted their eyes. She was just another defective ‘thing’ requiring fixing. Like Jenna’s surgeon, this surgeon was not interested in her history. He also stayed on the surface to present the thinnest veneer of professionalism but made little effort to conceal his disdain. Under his gaze she was a repulsive object, abject.

Amanda ran her own consultancy company and employed one hundred and twenty people, but in this setting she was reduced to a 'grubby little ...' what? Child, perhaps?

Amanda's detailed description was a master class in shame. The surgeon and his 'incredibly parental' receptionist reduced Amanda to shamed status by denying her embodied presence. She was neither seen nor heard. Her shame was manifest in the loss of her social position to that of 'grubby' childlike status. Shame is infantilising. Recall Freud's point that shame belongs to the realm of childhood experience. Freud underestimated shame, bestowing upon it a limited role confined to childhood (see Morrison 1989:3, 4). However, Freud's capacity to observe human behaviour was extraordinary and this observation remains astute. Almost everything demanded of embodied participation within social life is learned and acquired from within the hierarchical context of the family. Infants are dependent upon the care, feeding, cleaning, and indeed, grooming which they receive from others. As a child grows they are socialised to groom themselves and assume the management of their own body. Grooming is a complex social behaviour which exposes the inherent dependence of individuals on wider social groups. Through grooming individuals also display social allegiances and individualise statements of the self. Grooming is a prosaic, self-orientated and social activity, but failed grooming is associated with potential shame. Body shame is learned in childhood because it is considered childish to lose control of one's body. However, as Amanda's account demonstrates, shame at any age is significantly implicated in failed grooming. The parameters of what is acceptable, or not, in relation to the body and its presentation are emphatically bounded, drawn out in unequivocal lines demarcating binary oppositions, good and bad, acceptable and unacceptable, and the consequent subject and abject. According to Kristeva (1982), the formative experience of differentiating the self from its bodily waste constitutes the conceptual model from which notions of self and other are formulated. Moreover, she argues, it is along similar lines that the parameters of the social world are drawn and the conditional prerequisites of embodied social participation are introjected. Kristeva writes that 'abject and abjection are my safeguards. They are primers of my culture' (1982:2). Shame, then, is the subjective experience of recognising oneself as abject or potentially abject.

Shame might be learned in childhood, but Amanda's experience demonstrates how shame can be reinvoked. Shame is so instantly familiar, and so readily recalled, precisely because of its association with social failure in childhood. Despite being close in age to the surgeon and his receptionist, Amanda experienced them as disapproving parental figures. Her account demonstrates how non-benevolent hierarchies might readily induce shame. Their disdain reduced her to matter out of place, something dirty (Douglas 1966), childish and shameful; something that polluted their glamorous surgically enhanced universe of skin-tight beauty. She was like contagion and they expedited the encounter by dismissing her as soon as they could. Amanda felt shamed because they conspired in their shared views of physical beauty, whether consciously or unconsciously, to classify her as abject.

Amanda did not indicate any body image fragility as a child, nor was there evidence in her overall account to suggest that she was in any way prone to shame. She gained weight as an adult but denied that she felt marginalised as a bigger woman. She described a comfortable, loving family and professional success. A rise in her blood pressure and the concern of her GP persuaded her to engage a weight-loss programme. Amanda's consultation with the cosmetic surgeon contrasted with her usual life experience, which may account for the very clear assessment and description of the encounter that she gave. By her own account she was 'traumatised' by the event, but her experience was temporally and spatially specific. In his surgery the surgeon and his receptionist left her little choice but to accept their version of her. In their presence she felt acutely shamed, but not to the degree that she conceded to their disciplinary regime. Away from their gaze she was able to amend her sense of self. She dispelled their imposed shame by retelling her story to a girlfriend over a bottle of wine. She embellished the ridiculousness of the scenario and the freakiness of the receptionist, and recalled having a good laugh at their expense. Amanda felt compelled to do this because she needed to feel 'normal' again after that event. Lewis (1971:204) writes 'laughter is ... a corrective or release for the feeling of shame.' Several months after her first experience Amanda did, tentatively, approach another surgeon. On this occasion she approached the consultation as someone 'commissioning' a surgeon to do a job for 'her.' The second surgeon treated her as a peer. Their exchange was mutually respectful. He was empathetic, listened to her story and did not turn away from her body. This provided a contrast to her

previous encounter where she was not considered worthy of being heard and nor was she was worthy of the visual engagement of the surgeon or his receptionist.

An important observation needs to be emphasised about Amanda's account. Amanda reached adulthood with relatively good body image and she continued to have good body image when she gained weight as an adult. It is probable that the intactness of her body image afforded her a degree of resilience and may well have insulated her in negotiating and resolving the shame-inducing experience she described above. Her experience can be compared to those who developed poor body image in childhood. Women who described a history of poor body image acquired in childhood identified body image anxiety as a more persistent feature of their adult experience of embodiment. Furthermore, persistent body image anxiety in adulthood appears to be fuelled by the unresolved and often unconscious traumas of the past.

In general terms, the institution of medicine attends to grooming (Barilan 2002), and there is no specialty where this is demonstrated more literally than cosmetic surgery. Cosmetic surgeons claim to address the psychic injury incurred through the medium of body image. They seek to ameliorate the problematic relationship which women have with their body images by surgically altering their appearance. Women in this study did describe their pre-surgical body images as loathed and it was this they sought to resolve with surgical amendment. Moreover, because body image is constructed within ongoing social interaction (Schilder 1950), poor body image tends to be contextualised as emerging from within difficult social dynamics. Participants could be divided into those who characterised their initial surgeries as a desire to resolve a form of psychic wounding, and those who initiated surgery to pre-emptively manage potential wounding. Here the catalyst appeared to be the anxiety manifested in the dread of real or potential social exclusion. In many ways grooming industries attempt to access and reinvigorate such fears because they are so emphatically inculcated in childhood, and readily recalled in adult experience.

Within the power dynamic of patriarchy, women are always, to some degree, infantilised. A woman's body with its permeable orifices bestows 'her debt to nature' and imposes her

abject status (Kristeva 1982:102). She is shamed when she accepts this view of herself. Shame-inducing structures pervade and undergird the terms under which embodied social life is enacted. The potential for women to feel shame is ubiquitous and potentially overwhelming. The epistemological structures informing body image construction within a broader cultural context frequently amplify residual experiences of corporeal mastery emerging from childhood learning. Persistent associations with expectations of mastery at the level of the body are deeply implicated in the shame dynamic. Taking these associations into account and recognising their concurrence with wider projections of culturally preferred ideals of womanhood, against which so many women inevitably fail, gives some insight into how shame is overlain, amplified and reproduced. Failing to mirror the “ideal” reiterates and confirms failed mastery at the level of the body. Jenna understood this perfectly, expressed in her desire to ‘look like a well-kept woman.’ Shame based associations interweave familial socialisation and broader cultural constructions defining the terms under which one might be both female and embodied. They reflect, reiterate, reproduce and reinforce overarching values defining how women and their bodies should strive to appear. This may explain why a woman’s relationship to her body image is so profoundly vulnerable and, furthermore, so readily exploited by grooming industries whose fortunes are reliant upon vitalising body image anxiety. Bodily shame is learned in the context of early socialisation and grooming industries appeal to, capitalise upon, and perpetuate its intimate and familiar, or better familial, disciplinary regimes.

Working women, body image and shame

In analysing the transcripts it became clear that body image dissatisfaction was exacerbated and amplified in particular settings. I have contended that body image fragility for some women is a cumulative process that has its genesis in early childhood experience and, rather than dissipating with age, becomes increasingly tangible in adult life. At the other extreme were women for whom body image dissatisfaction was a recently experienced phenomenon. For this group, cosmetic surgery and grooming technologies were discussed and embarked upon in much more pragmatic ways. Unlike the women who experienced deep shame and entrenched body loathing, a perceived bodily flaw was evaluated, assessed and a surgical solution sought, which in most situations appeared to ameliorate the problem. Of course

there was not always a clear delineation between these two particular groups, as an environment such as the workplace could easily reinforce body image dissatisfaction in those for whom fragility associated with body image was more consistently problematic. However, in the interests of presenting a clear argument, the next section will focus on the specific problems associated with body image that participants identified as being explicitly relevant to their engagement in the workplace.

Many participants had come to view the lines and contours of their physical appearance as a potential liability, particularly in workplaces where women were making inroads into professional domains and positions of authority traditionally held by men. For one participant, a professional woman in her late forties who I have named Yvonne, negotiating body image was, for her and a small cohort of equally accomplished female friends with whom she routinely discussed such matters, a carefully managed exercise. Their work involved a broad range of public exposure across political, media and education sectors. While cosmetic procedures had been engaged by only one member of this group, cosmetic surgery had frequently been discussed as a potential tool to ameliorate the challenges these women felt they faced in 'being taken seriously' as older an woman in the professional positions they held. I include Yvonne's experience as women have traditionally networked orally and an increasing discussion amongst women is a significant mode in which cosmetic surgery is progressively becoming normalised. Yvonne herself had not undertaken cosmetic surgery, but it was her expressed understanding of the reasons for women engaging such procedures that led to her participation in this study. Her interview was insightful for what it revealed about the concerns that she and her colleagues share around body image, ageing and the extraneous challenge which body image presented to their employment. Yvonne described being an older professional woman as a 'barrier,' a perceptual hurdle that she actively managed to ensure that she was 'taken seriously' by the diverse range of clients she engaged, some of whom she believed had difficulty differentiating between professional middle-aged women and the stereotypical roles they were once confined to. (Gimlin 2006 also utilised the term 'barrier' to describe the physiological limitation her participants' pre-surgical bodies presented to their engagement in social life). When I asked Yvonne to elaborate upon what she meant by a 'barrier' she replied:

Yvonne: Well, looking decidedly middle-aged. Middled-aged women in our society, even though more are becoming prominent, are heavily undervalued and quite often resented. There is a feeling that middle-aged women are a bit of a bother. They are just devalued ... (She clarifies) There are middle-aged women and middle-aged women, and if you can present as very well-groomed, as a well-kept middle-aged woman, you can do OK. But once you get a bit frumpy around the edges ... then you have a battle on your hands to get people to take you seriously.

Jane: I don't think older women are seen in the same way as men when it comes to ageing.

Yvonne: *Oh absolutely not.* An older man can add gravitas and authority to ageing. For an older woman, ageing *never* adds gravitas. It might add some authority but it all depends on presentation. Take a woman like Hillary Clinton who has made it very clear she has had a facelift and various other cosmetic surgeries ... I'm sure Hillary Clinton doesn't mind being better looking, but I'm sure being better looking was not the driving force. It was about making sure she was able to achieve what she wanted to achieve without being dragged down by the way she looked (original emphasis).

The disparity between the way in which older men and older women are *permitted* to age was keenly voiced across the interviews. Patricia too linked gender and ageing to an impression of professional competency. Patricia held a senior position in a large public company and had just undergone a facelift at sixty-two because she 'did not want to come across as a retired elderly person who can't do their job.' Being female and older is at odds with a notion of workplace competence and it is this stereotype which she hoped a more youthful face would redress. For Patricia, cosmetic surgery was a pre-emptive grooming strategy enlisted to sustain in others the confidence that she was competent to continue and maintain her professional position. Like Yvonne, Patricia was well aware of the differences in meaning assigned to men and women when it comes to ageing and the associated impressions of competency they carry.

A distinguished grey haired man can get away with a lot more than a distinguished grey haired woman. I think there is a perception in the world that older women are CWA sort of women that they have lost their brains or something ... It is assumed they are grannies. And men, well, successful men, don't have that image however old they are (Patricia).

Patricia also noted the degree to which these value judgements are entrenched. She was deeply offended by their underlying prejudices, but she herself conceded that she was not divorced from presuming that older women were retired rather than powerful players in the workplace. When she was out and saw a well dressed woman she too tended to think along stereotypical lines.

Patricia: I guess I probably do it too, although I'm training myself not to. When I see an older woman out with children, my first instinct is not to think "There's an older professional woman." I think, "There's an elderly grandmother and those are her grandchildren." She could be the head of BHP, but no one thinks that. That's not the first thing that crosses their mind. Even if you see a well dressed mature woman you don't think "Oh, she's on her way to a board meeting," you think "Oh, she's off to the Wentworth to have lunch." And I believe people think you should have retired. And I don't want anyone to think that. I'm not ready to retire, so I don't want to look ready to retire either.

For these women, impression management through grooming was unequivocally nominated as a careful labour invested in workplace body image and, was considered necessary 'to get people to take you seriously' (Yvonne). As a middle-aged woman, Yvonne concedes: 'we have to try a lot harder with our grooming, with our clothing.' For Yvonne, workplace grooming was carefully tailored to specific workplace contexts, but her overarching concern was to convey competence, credibility and professionalism. Furthermore, Yvonne made a finer distinction about the group she found to be most confronted by her gender and her age. She nominated particular groups of men whom she encountered when working as presenting her with the greatest challenge.

Men who are in their 30s and 40s are the group I find the most difficult. They can be very judgmental about women and will be looking for a reason to negate you. I guess that's because it's around, I don't know, personal pride and things. Some men around that age really resent being around a woman who is in a position that has more status than they have (Yvonne).

'Devalued,' 'being dragged down by your looks,' 'incompetent,' and 'resentment' were the terms Yvonne employed to describe the potential bias she believed that she, as a professional

middle-aged woman, must guard against through careful grooming and impression management. For Yvonne, grooming specifically tailored to workplace conditions was described as a defensive strategy to deflect potential hostility. She suspected that her workplace status threatened the pride of men who were a generation younger and unused to the changing role of women in the workplace. By invoking notions of threatened pride Yvonne raised the possibility it was her authority that potentially threatened to shame them. Yet she too was potentially shamed by not being taken seriously if her appearance failed to convey competence. She articulated her own body image as something *she* must manage as a way of managing other people's responses to her (Gimlin 2006 makes similar observations). On perpetual display, women are vulnerable to being negatively sanctioned in ways that men are not. As Yvonne emphasised with her example of Hillary Clinton, a faulty appearance can become an impediment to professional functioning. Appearances represent socially mediated projections of the self and a faulty appearance suggests that the self is also faulty. While women potentially accrue a great deal of social power through being admired for their appearance, any such capital can just as easily be undermined by an outward appearance which is deemed to be flawed, because it is never just appearance alone that is being evaluated. Rather, the self, and the appearance of the self, are fused together in the view of an evaluating other. Notions of competence and authority, characteristics of the self, are evaluated through appearance. Yvonne and Patricia experienced their body images as sites of potential vulnerability. They managed their workplace appearance defensively as strategies that allow them to work unhindered and unimpeded, to avoid being dragged down by the poor evaluations of others and to stem the tide of shame which can, as a result, so easily pervade and undermine the self. Yvonne and Patricia were part of a cohort of women who are, in effect, pioneering roles in positions of power traditionally held by men. Their presence challenges stereotypes, but deep seated prejudices and resentments persist. Whether subsequent generations of women will feel the same vulnerability, and feel compelled to manage their workplace appearance as defensively, remains to be seen.

Yvonne's close attention to meticulous grooming was far from isolated in this study. Another woman employed in the executive sector, and therefore representing one of a very exclusive ten percent of women who have reached this elite professional zone, spoke of

equally fastidious attention to personal grooming. When interviewed, Anne was in her early fifties and had undertaken cosmetic facial surgery. She cited a number of reasons for seeking surgery, including improving her vision, but she, like Yvonne and Patricia, spoke at length about grooming as careful labour invested to ameliorate signs of ageing and convey an impression of workplace competence:

For me, it (an eyelift) was more about, about trying to retain an image at work and not starting to look too old for the job. I really went to great trouble, I wore excellent clothes and I looked after my skin, I always had manicures done. I had all of that stuff done and my figure was a nice size 12 (Anne).

Anne, like Yvonne, echoed underlying workplace tensions specifically around gendered power shifts. Both women identified and discussed hostility in the form of resentment as a negative feature of their working lives, one which shadowed their professional success. In Anne's case it was from her colleagues whom she experienced such resentment.

When you are a woman working with men, they do not give allowances to women, of bald or grey hair, it just doesn't work ... I've worked on boards, where I was the only women and the rest were men and ... I did feel put down a number of times ... That glass ceiling is well and truly there and when you break through it and become successful, there are quite a lot of men, male colleagues, who become very bitter that you outstrip them. They don't like it, and they'll make up terrible stories about you. *Slandorous* (Anne, original emphasis).

For these women body image was managed defensively. They discussed their appearance as sites of potential vulnerability and nominated grooming as a central feature of their strategic toolkit to manage it. Anne's presence on numerous male dominated boards took her into the segregated bastions of the men's club and gave her unique insights into institutionalised patriarchy. On one occasion her employer was required to confirm her reputation before she was permitted to enter an establishment as an un-partnered woman:

Once I stayed at a very exclusive club but before they let me stay there as an unaccompanied woman my chairman had to write to the president of the club saying, even though I am a woman,

I am a person of good repute. And they wrote back and said: "OK, well, we'll sign her in as an honouree man" (she laughed with incredulity) ... When I arrived I was escorted to my room and then we'd go down and have dinner. There were a couple of occasions when I was the only woman at one of those important dinners. Business was discussed and then the chairman would say "Ah, well Anne, we'll all say good night to you now, we are off to play pool and women aren't allowed into those areas." It was ridiculous (Anne).

Anne's attendance at these meetings was spatially regulated as the areas of the club accessible to her were clearly designated. Such demarcation meant she could easily be dismissed as she plainly was in the example above. However, it was the detail of her self-initiated grooming ritual that I found most interesting:

There was always pressure, in a cosmetic sense, at any of those dinners. They (her male colleagues) would just arrive and turn up in their suits, not having had a shower, while I would rush up to my room, shower, put fresh clothes on and a bit of make up, and then rush down, because you were expected to look good, but look as if you haven't made any effort to do so. It was the expectation (Anne).

Anne felt 'pressure' to wash and re-dress. She cleansed herself prior to regrouping with her male colleagues. There is an implied subtext within her actions which suggests that Anne felt dirty, that she had internalised the feeling that she, and her embodied femininity, were somehow out of place. The parallels are even clearer if we recall Douglas' (1966) definition of dirt as 'matter out of place.' Anne compared her own actions with her male colleagues and understood that in this setting she was 'other.' Her self-initiated cleansing suggests that she had incorporated their expectations about how her body was to be managed and presented within that particular setting. Moreover, she was not speaking of an isolated event since she is speaking in the plural: 'there was always pressure ... at any of those dinners.' The expectation she experienced was consistent: her presentation had not only appear immaculate but she also had to be clean. Anne was not articulating how *she* felt physically. She was not saying she felt the need to wash and change her clothes. Rather, her inference was that she felt compelled by her colleagues' expectations of her, expectations that her body required that level of attention which theirs did not. Despite Anne's considerable

professional achievement her concerns about her body have resonance with the long-standing vulnerabilities that many women have been socialised to feel towards their bodies. Their bodies are experienced as unpredictable, leaking and unclean. Thus for Anne, and women more generally, grooming rituals are as much contingencies enacted to guard against an ever-present vulnerability and the descent into shame an unforeseen breach of the corporeal boundary will almost certainly elicit.

Another participant, Jenna, also included workplace considerations as part of her motivation for undergoing cosmetic surgery, but as a means of improving her employment opportunities rather than defending a position she already held. Jenna's account was marked by themes of abuse, loss and surgical recidivism. Her consumption of cosmetic surgery and the justifications she gave for undertaking such surgeries were highly complex and multifaceted. It would be misrepresentative to suggest that improving her employment potential was the only mitigating factor she gave, but she did include securing employment as one of the central reasons for seeking her most recent surgery. Jenna reported a diverse employment history managing small businesses and working in the service sector. She hoped to move into middle management, but had recently relocated to another city where she had encountered difficulty finding suitable work. Her financial situation was precarious. Her second marriage ended badly several years before we spoke, she was currently single, had little in the way of assets and she had accrued debt with her most recent surgery. Jenna hoped her facelift would provide 'financial opportunities in order to survive the rest of my life.' This appears a uniquely gendered aspiration as it is unimaginable that a man would say such a thing. Jenna characterised cosmetic surgery as an investment in physical capital against which the variables of gender and age conspire:

I wanted to change jobs ... and I didn't want to be judged on my age. I didn't want my age to be an issue. I did a management course at a local college recently and they said, if you were over forty, not to put your age on a job application. Even though it is illegal to discriminate on the basis of age, it is still a big issue in the workforce (Jenna).

Like the women already discussed, Jenna nominated cosmetic surgery as a defensive grooming strategy enacted to ameliorate signs of ageing and maximise her employment potential. She also believed an aged appearance inhibits the employment prospects of women. 'Men,' she said, 'get more distinguished when they get older, whereas women don't; they tend to deteriorate' (Jenna). Her choice of the verb, 'deteriorate,' suggests that she envisaged a dank and abject world of rotting and filth awaited the ageing woman who let her self go.

The final perspective in this section comes from a young woman in her late thirties. Nicole had not had cosmetic surgery but worked with a woman whom she, and others she worked with, believed had had cosmetic surgery, and found her own body image affected. Her interview adds another layer of complexity to the conundrum which cosmetic surgery presents to women. Nicole and I were strangers who struck up a conversation at a public forum we both attended. From the onset it was clear that Nicole was concerned about the impact cosmetic surgery was having upon her body image and had given considerable thought to having surgery herself. It was her highly reflexive struggle to negotiate the conflicting dialogue of her own background, staunchly embedded in feminist ideology, and the everyday realities of both making a living and pursuing a career which led to her participation in this study. Any deliberation that Nicole had given to the possibility of having cosmetic surgery was related directly to investing in her employability. She had overcome considerable social disadvantage to complete a law degree as a mature-aged student. As a small child she had been a ward of the state. She now had her own children but her husband suffered from a chronic illness which would increasingly limit his capacity to work. Nicole assumed that providing for her family financially would eventually become her responsibility. When I asked her whether she was seriously contemplating cosmetic surgery, and for her reasons, she replied at length:

Yes, I have seriously considered it. And one of the reasons, I suppose, is the shows on television, you know *Extreme Makeover*, shows which seem to be quite miraculous. But mainly because I have just taken up a new position which I worked very hard to get. I had to do quite a lot to get this job, particularly as I am older and female. For instance, to get a foothold in the particular law firm I have just joined, I topped every course I took as an undergraduate across law and

science subjects at university. I was awarded university prizes and have been acknowledged for academic achievement at a national level. I've also had my work published in respected journals. Being older and female, I have had to do it very hard and hit the ground running. I worked hard because I knew that's what it would take for me to get this job. The positions are highly sought and very competitive ... When I started there I became aware there was another woman who had been appointed just before me, but she didn't have anything like the academic background I have. Nor did she have any particular experience. She is actually paid slightly more than I am, and she doesn't seem to do any of the things I have to do to keep my position there. Nor does she have a probationary period which I have. She is in her early fifties, and it is quite obvious to me and others that she's had quite a bit of cosmetic surgery, including very large breast implants, which a lot of people in the office talk about, particularly the older women. It's quite unsettling as she is very much a presence in that place and seems to have worked her way into a position based on her sexuality. It's very up front, very much part the lunchtime talk, very much part of the relations between clients in the way they react to her, and everything else. And I started to think, "Gee, is this what it takes to get a position?" Then I started to get a bit worried. I'd never felt old before, but now as I'm nearing 40 it suddenly occurred to me that perhaps ... what she has done is not really so bad, and that all this merit I have behind me doesn't really amount to much ... Employment should be about equality and egalitarianism, but in reality it is still about old men or men from the baby-boomer generation deciding who gets employed and who doesn't ... I was a bit thinner than I am now a few years ago, and I always felt that I was, you know, not sexual, but I was striking enough that men would be interested in me. That's kind of starting to wane a little bit now. So, that makes you start to think "Maybe I should get something done in order to facilitate some kind of economic provision for myself as I get older." I can't rely on my husband, so ... yes, it is a hard one. Lately I have found myself asking "Do you do this (have cosmetic surgery), or do you try and just go down the merit pathway?" I find myself questioning, ultimately, how hard do I have to work to get a bit of decency in my life (Nicole)?

Comparison is a notable feature of Nicole's discussion. She measured her own academic history against that of her surgically enhanced colleague and compared her own appearance when she was younger with her appearance now that she was growing older. She also used comparison to orientate and locate herself within the hierarchies she observed around her. Nicole did not harbour resentment towards her colleague, but her colleague's use of surgery appalled her because it not only exposed the gendered discrimination which older women

face in developing their careers, but also underlined the extreme measures her colleague had engaged to secure her position, which left Nicole questioning what she might be required to do to further her own career. Reviewing the stalled careers of the other older female colleagues in her office filled Nicole with rising alarm. However, it was the creeping pragmatism with which she was increasingly coming to view cosmetic surgery herself which proved most confronting:

Nicole: There are a couple of other women in the office who are about 15 years older than me. They have been overlooked again and again for promotion and I think they kind of just feel past it. They almost feel as though it's too late for them. And so, as somebody who is a bit younger than they are, I just look at them and think "Christ, I don't want to end up like them, in a junior position when you are in your 50s." One of them has been widowed and it's going to be very difficult for her as she is on a contract position. Somebody actually said to me a couple of weeks ago that she looked like a corpse, because she is getting a bit older and has wrinkles on her face. Now, we have a senior partner there who is much older than this woman and he is far more unattractive than she would ever be, but no one ever makes a comment about him. He is seen as being powerful and all-consuming ... But you know the first thing I thought was "Perhaps she should get cosmetic surgery." And then I thought, "God, you know, for God's sake, *what*" (said with a kind of horror that she actually thought that)! I am a feminist, but.... . (affirming) *I am a feminist*. I read Germaine Greer when I was 16 years old and it made a terrific impact on my life. I was one of the first women to be involved in anti-war marches in the early 1980s. I have lived in all-women households where tradesmen had to be tradeswomen because we would not have a man on site. It was fairly radical stuff. But here I am in this situation now, which is, if I had the money maybe I would go ahead and have cosmetic surgery.

Jane: So what are your attitudes to cosmetic surgery, do you feel particularly negative about it?

Nicole: I think that cosmetic surgery is dangerous because it denies women the right to simply be themselves and it denies us the right to have bodies that manifest in the ways that they do which is normal and natural, whatever that may be. And it places an enormous amount of pressure on all women ... It has become irrational, the way I feel about it. I guess it gets down to that bottom line: I want to get a decent job and support my family. I come from a fairly impoverished background, so financial security is extremely important to me. It doesn't matter how good I am at my job, if I have to compete with women who get positions based on their sexuality, then I'm going to learn that game pretty quickly. And if learning that game means

that I have to do what they do, then I might start considering it ... But I haven't done it yet (she quickly adds; original emphasis).

Nicole's discussion illustrates how the underlying reasons which motivate women who undertake cosmetic surgery to improve their own body image flow on to affect the body images of others who do not. Nicole was not critical of her colleague's actions - perhaps she had done what she needed to do to get some decency in her own life - but neither Nicole nor the other women she worked with were immune from feeling body image anxiety as a result of the way in which their surgically enhanced colleague displayed and used her body. While women who undertake cosmetic surgery almost always assert agency and privatise their actions by claiming to be doing it for themselves and themselves alone, Nicole's experience suggests otherwise and reiterates that having cosmetic surgery is far from a private act. Her colleague's actions upped the ante, which left Nicole asking if she needed to do the same.

One longitudinal study undertaken in America found a consistent relationship between law graduates' appearance and income level. Those considered most attractive gravitated to the private sector where they earned much higher incomes (Biddle and Hamermesh 1998). Systems of aesthetic stratification (Synnott 1993) pervade the social world and individuals almost certainly have an intuitive sense of their status within such systems, as Nicole's own reflection upon her appearance as a younger woman illustrates, but abstraction blurs the boundaries and the subjective nature of preference and attraction undergirding these structures makes it difficult, if not impossible, to formulate judicial responses to enactments of their prejudice. Engaging cosmetic surgery, then, remains a private solution to what is a social problem of aesthetic and gendered inequity (Haiken 1999, Davis 1995, 2000). Unpacking the way shame operates in undermining how women feel about their appearance and developing strategies to develop resilience towards shame may provide one solution.

Nicole did not describe body image anxiety as a child, but she made it plain that the impoverishment of her past shadows her adult ambitions and was clearly implicated in her anxiety. Her efforts to forge a well paid-career have been part of a long term and committed plan, and she had worked hard to achieve her success. To encounter her body image as

flawed was disorientating and disconcerting. It destabilised her core feminist beliefs as she found herself entertaining thoughts she would once have considered heretical. Should she subordinate herself to the ideals imposed by powerful male baby-boomers and have cosmetic surgery to ensure that she was still in the running to be employed, or not? Risking being out of the running was not an option either. Considering her surgically enhanced colleague was in her early fifties, was what she has done 'really so bad?' Nicole believed the way she had come to think about the situation was 'irrational,' but the intensity of her feelings drew upon the deep shame associated with the poverty reverberating from her past, which was further inflamed by the injustices she observed proliferating in her workplace. Moreover, it was Nicole's realisation that her academic efforts alone might be insufficient to secure her professional future that was so profoundly unsettling. She was ambitious and was fast realising her opportunities to further her career were narrowing. Observing her surgically enhanced colleague presented her with a dilemma, one which made her question how far she could, or should, go to realise her own ambitions.

Nicole, along with others who spoke about the impact of body image in the work setting, had no doubt about her intellectual capacity to succeed professionally. Therefore, her countenancing of cosmetic surgery must be recognised as a contingency to avert the potential shame of dependence and failure that would ensue should the trajectory of her planned career falter. Nicole's response was less about body image loathing than about the inequalities which older women face in a culture that invalidates ageing, and the ageing of women in particular. Any body modification that Nicole might undertake would relate more to shoring up her professional aspirations and less with her own body image dissatisfaction. However, if she were to have cosmetic surgery she would have to concede that her body image had fallen below the standards of another, and any enactment of surgical modification she engaged would imply she had accepted their imagined evaluations of her as her own. This in turn would suggest that she had experienced her own body image as something shameful, unacceptable and requiring amendment. Measuring herself against an ideal proposed by another and contemplating the initiation of any change that would move her closer towards the preferred ideal of the other, confirms the model of shame proposed by Lewis (1971).

Shame underpins body image anxiety, which gives rise to the initial consideration of cosmetic surgery. This chapter has sought to look closer at the interactions that participants identified as those which heighten body image anxiety. As with formative socialisation, it appears that interactions with significant others impact body image, but it is when these interactions destabilise body image that shame appears energised. Moreover, it is in response to subsequent shifts in identity that cosmetic surgery finds its market. Cosmetic surgery thrives on the imaginations and fantasies of the uncertain. It finds its niche in responding to the anxieties of tentative, fragile and recuperating identities. Under the wider banner of institutional medicine, cosmetic surgery provides structure and ritual through which those who perceive their external identities to be flawed might re-emerge remodelled and in keeping with a surgical ideal. However, there are problems for women more generally as the surgical ideal denies modern women ‘the right to have bodies that manifest in the ways that they do which is normal and natural’ (Nicole). Women who engage cosmetic surgery may disagree, and say that cosmetic surgery has transformed their lives, as Gina did after she had her breasts augmented, but it is not the outcome of surgery I am referring to here, but the process of self-evaluating body image that precedes surgery.

Collectively, the cosmetic surgery industry proffers its ideal of skin-tight beauty as “the ideal,” and the very success of the industry as a whole is dependant upon women scrutinising their appearance and agreeing that they need amending towards that ideal. Following the model proposed by Lewis (1971), it might then be suggested that the cosmetic surgery industry applies strategies which attempt, in the first instance, to invigorate shame in women who are unhappy with their appearance. Such a manoeuvre appeals to and confirms other shames that women acquire through earlier corporeal socialisation. This includes managing the messiness of their margins and an introduction to the dangers and pleasures of sexuality: responsibilities which will always be hers alone. Early socialisation also includes being inculcated to particular ideals of preferred feminine appearance, not just via media, but affirmed and conveyed in the attitudes of significant others. They too are immersed in a visual universe, and perhaps struggling to manage their own shortfalls in meeting corporeal ideals, but when they accept the social mandate of such ideals they become, inadvertently, conduits through which the collective corporeal values of the wider culture are transmitted.

Their values are then substantiated, confirmed and reinforced by other agencies long after primary socialisation. However, as accounts from this study suggest, formative experience remains important because social rules are introjected at the feet of those most loved and trusted, at a time of irrefutable dependence, when identity is most vulnerable and its boundaries liquid. One's own body and its management is the very first social responsibility and it is shame, with its clearly defined parameters and punitive regimes, which is the first law. However, shame as a system of introductory childhood learning has a corrective agenda. The shamed child is directed to look at themselves, to understand that they have offended against a social rule, and accept that they must change by correcting their behaviour and making amends. Cosmetic surgery, it would appear, is opportunistic in accessing the shame of poor body image. A woman, looking towards her own body image and questioning its very worthiness, already well schooled in embodied shame, turns to the model of surgical amendment in recognition of the correction it purports to offer. Cosmetic surgery, in line with other grooming technologies, taps into and appeals to familiar shame structures.

Relentless exposure to a visually mediated universe bent on steadily narrowing the socially and economically validated range of available ideals suggests that women may always share a collective vulnerability to shame because approximating such ideals was never intended to be attainable for the majority of women. Cosmetic surgery, in co-authoring the ideal, is able to define the parameters of the problem while concomitantly proposing a surgical fix. The very success of the cosmetic surgery industry lies in its capacity to mobilise shame within individuals while simultaneously seducing them with the salvation of a restorative agenda. Physical appearances are the fault lines upon which social selves are constructed and evaluated, and because selfhood and external appearance are so readily conflated in face-to-face interaction, this is unquestionably more the case for women, the outward appearance of women frequently demands dedicated impression management. The self encounters the social meaning of its projected appearance through the subjective experience of body image, and body image is in turn managed within frameworks of comparative evaluation and self-appraisal. In countenancing cosmetic surgery the self appraises and accepts its body image as faulty and in need of amendment. The spectre of faulty body image threatens to pervade the self with shame. Shame associated with body image reflects a particular form of injury

directly related to looking at the self, an injury which impedes the viewing self filled with love for its image. Shame has been termed an injury of narcissism, and there can be no more appropriate instance when this definition of shame might be applied than when poor body image evaluation results in shame. Moreover, there can be no technology of the self more appropriately termed narcissistic than grooming initiated to improve the appearance of the body. Shame as a topic for exploration suffers from the collective ignorance of being overlooked as unworthy of analytical discussion. However, an unlikely discussion of shame was found in the mythical story of Echo and Narcissus, written by the Roman poet, Ovid (1997, 2004), some 2000 years ago. The final chapter of this study rereads this seminal story, along with selected texts, in an attempt explore the link between shame and narcissism.

Chapter Eight: Just Look at Yourself

At the commencement of this study there was a desire on my part to explore the processes that women who feel compelled to alter their appearance with cosmetic surgery negotiate. I felt sure that there would be a more complex explanation than the common assumptions which malign or rather, shame women who undertake such surgeries by characterising them as merely vain or narcissistic. However, as the study proceeded, it became increasingly obvious that narcissism, a term which is clearly contentious, is implicated in resolving shame. Despite Freud's (1914) attempt to understand narcissism as normally enacted behaviour, it was evident from the reading undertaken for this chapter that little headway has been made in formulating narcissism in a normative form. The term "narcissism" is most frequently associated with clinical pathology. This chapter explores the way in which we have come to understand narcissism. It draws from selected texts, which include the Ovidian (1997, 2004) poem, to argue that the conceptualisation of narcissism has been overshadowed by pathological connotation which occludes the possibility of understanding narcissism in alternate ways. This chapter proposes that shame, and the threat of social exclusion that underpins it, presents an occasion for narcissism. Shame must firstly be acknowledged as a shared social phenomenon which is centrally important to the way in which we learn to become physically and socially embodied. It is directly implicated in the management of the body's boundaries. Moreover shame, and the narcissism the self employs to manage the physiological and aesthetic dimensions of embodiment, affects and shapes social life. Grooming practises, and in particular those associated with the presentation of the body, are located at the nexus of these ideas.

Schilder (1950) did not discuss shame but he understood that narcissism was implicated in body image construction. He wrote: 'We have to expect strong emotions concerning our body. We love it. We are narcissistic' (Schilder 1950:15). Schilder understood implicitly that the dedicated concern for one's body and its appearance is hardly abnormal, but experiencing one's appearance as loathed in the extreme, or substandard in the least, characterised the descriptions of the pre-surgical body image in the accounts of those who took part in this study. They had clearly not always loved their body's appearance, but their

natural inclination was to want to love it. My interest in the relationship between shame and narcissism developed over the course of this study and the discussion which follows is introductory at best. It is offered by way of final observations taken from this research and suggested as a recommendation for future study. Shame and narcissism this chapter argues, are more effectively understood as interrelated concepts closely aligned to the psychosocial processes of self-evaluation and correction. To consider narcissism in isolation from the conditions which precede it is a serious oversight. While narcissism is commonly understood as a personality disorder, this chapter proposes that limiting its meaning to pathology excludes the possibility of understanding shame and narcissism as related phenomena.

Shame is a structure of self-regulation through which the wider rules of culture are learned and sustained (Elias 1978). The shame dynamic is first encountered in childhood. Those who breach the social rules of their group are directed to enact the shame sequence. They are instructed to remove themselves from any given social situation and to reflect upon themselves with a view to correcting their shamed behaviour before being reincorporated socially. Those who are shamed are directed “to look at themselves,” to recognise their faults and initiate action to amend themselves to a standard deemed satisfactory by significant others. Shame demands self-reflection, self-evaluation and self-correction. Actual and imagined perceptions of social exclusion threaten the shamed subject. Shame provides a framework through which the self assesses and manages its own performance in accordance with prevailing cultural ideals. Through learned shame structures, and the corrective function narcissism provides, the self regulates and maintains self-esteem and manages social status. Narcissism, this chapter proposes, is a strategy enacted to correct the shamed state.

Linking shame and narcissism is not a new idea. The small group of psychoanalysts who have studied shame suggest that shame is a form of narcissistic injury. Shame has been described as the ‘veiled companion of narcissism’ (Wurmser 1987) and the ‘underside of narcissism’ (Morrison 1989), but whether shame initiates narcissism, as appeared to be the case in this study, is not entirely clear. Lewis (1971:89) proposed, on a behavioural level, that shame tends to evoke restitutions or narcissistic affirmations within the self. Moreover,

she argued that shame which was *not* corrected could lead to ‘psychic symptoms’ (Lewis 1971:27). Her observation shifts narcissism and its corrective relationship to shame from the extreme of pathology towards a normative behaviour enacted to amend shame. In later work Lewis (1987b:94) proposed that shame and narcissism ‘overlap’ since the self is positioned centrally in both. Narcissism, Lewis 1987b:95, 96) wrote, ‘is a positive experience of the self’ which is recognised as ‘a defence against the hatred of the self in shame.’

At the same time Lewis (1987b:95) was writing about shame, others in her field described a similar type of patient whom they classified as the ‘narcissistic personality.’ Writing independently, Lewis (1987b:94), however, proposed that shame lies at the root of behaviours more commonly diagnosed as narcissistic. She reanalysed case studies published by her peers, including studies published by Kohut and Kernburg (in Lewis 1987b:92-102), both influential psychologists writing on narcissism during the 1970s, to suggest that they had failed to identify the shame which she demonstrated was evident in their patients’ histories. Furthermore, Lewis (1987b:101) argued, the grandiosity, arrogance and conceit which clinicians levelled at the patients they diagnosed as narcissistic was accusatory, infantilising and, ultimately, shaming. Lewis steadfastly maintained that shame had been overlooked in the manifestation of narcissistic behaviours.

Narcissism, however, remains conceptually contentious. Contemporary understandings of narcissism have emerged in the long shadow of Narcissus, ill-fated youth, and icon, Spivak writes (1993:22), ‘of mortiferous self knowledge.’ Although primarily associated with the psychiatric pathology, the term “narcissistic” is readily used in the non-clinical setting as a shameful adjective to describe anyone deemed to take an unhealthy interest in themselves, and their appearance in particular. Any reading on the subject of narcissism eventually leads back to Ovid’s (1997, 2004) poem but I found in Narcissus a profound example of failed narcissism. Desired by many but, in the end, Narcissus is unable to be loved or to love himself. Tragically alone, he is a failed social subject. I turned to Ovid’s poem in an attempt to understand narcissism and quite unexpectedly found a sophisticated illustration of shame, which appeared relevant and worthy of inclusion in the current discussion.

Narcissus and Echo

'Narcissus and Echo' is a slim entry contained within Book Three of the epic poem *Metamorphosis*, in which Ovid explores the themes of identity and transformation. The story telling of a youth who is fatally entranced by his reflected image is well known but Echo, whose shame-laden role reflects that of Narcissus, is less well remembered. This is unfortunate since it is Echo's experience of shame, reflected and replayed by Narcissus, which suggests that Narcissus' demise occurred as the result of profound, unamended shame. His inability to resolve his shame takes him to the brink of abjection and renders him finally an unviable social subject; whereas Echo, who is compelled to witness Narcissus' suffering, transcends her body and her shame to become a superior character than she had previously been. The story, however, begins with a rape.

We learn in the opening lines of Ovid's poem that Narcissus was conceived when his mother, the water nymph Liriope, was raped by the river god Cephisus. Some time after his birth Liriope consulted the blind seer, Teiresias, to determine whether her child would enjoy a long life. He predicted that Narcissus would live a long life provided he did not know himself. Although initially baffling, at sixteen years of age and on the threshold of manhood the seer's prophecy began to make sense. Narcissus was unusually handsome and attracted the attentions of both men and women, but his 'heart was so hard and proud' that none of his many admirers, 'the lusty men and languishing girls could approach him' (Ovid 2004:109). One day when he was out hunting the young nymph Echo caught a glimpse of Narcissus. Captivated by his beauty Echo began to follow him and, as the distance between them diminished, her desire for him grew.

Ovid's protagonists were deeply flawed and incurred specific punishments for their social indiscretions. Echo's intentional chatter had earlier kept the goddess Juno engaged long enough to hide her husband Jupiter's adultery. When the deception was exposed, Juno was so infuriated that she punished Echo by removing her capacity to originate speech and as a consequence Echo could only repeat the last few words of another's sentence. Echo followed Narcissus, longing to engage him but she had to wait for him to speak. The opportunity arose when Narcissus became separated from his hunting party. Sensing he was

being followed and hoping to be reunited with his fellow hunters, Narcissus called to the unknown pursuer. Echo fashioned her response from his calls and when Narcissus called out 'we must come together' (Ovid 2004:111) Echo seized the opportunity to repeat his reply. She burst forth into the glade and attempted to throw her arms around him. But Echo had mistaken his call for an invitation to love and was devastated when Narcissus recoiled in horror, exclaiming 'May I die before you enjoy my body' (Ovid 2004:111). Humiliated, 'scorned and rejected, with burning cheeks, she fled the forest to hide her shame and live thenceforward in lonely caves' (Ovid 2004:111) where her body slowly withered away. Although eventually disembodied by the violence of Narcissus' rejection, Echo survived her body's death to continue on within the text as a character in the form of an echo, 'as a subject containing a sound' (Nouvet 1991:114) and, despite her deep shame and consequent mortification, her love for Narcissus persisted. From a distance she continued to watch him.

Following the desiccation of Echo's body (the chronology of the text is somewhat ambiguous here) Narcissus too was cursed when an anonymous admirer appealed to a higher power that he should suffer, as he had made others suffer, by falling in love and never obtaining his desire. Nemesis, the goddess of retribution, deemed the request to be just and the scene was set for the unfolding of events by a dark, isolated, pool, deep in the forest. Fatigued from the hunt Narcissus dropped to the water's edge to drink but was drawn to the vision of beauty his own reflection issued forth. The reader at this point is positioned within the text as an observer watching Narcissus engage his own reflection. To the observer Narcissus appears trapped in self-adoration, which is how the story is usually remembered, but Narcissus made a fatal error and misrecognised his own image. He believed the figure before him was that of another. Under the effect of the curse, Narcissus did not experience self-love but the desperate desired to be loved. Eschewing food and sleep, Narcissus implored his beloved to join him.

Ovid switches from narrative to soliloquy to convey Narcissus' growing torment as he attempts to converse with, and elicit a response from, his image. Narcissus puzzles at the similarity between his own feelings and those expressed by his lover as his frustration and despair mount. He weeps, his lover weeps, he smiles and his lover smiles back, but still they

do not touch. Reminiscent of the earlier scene with Echo, Narcissus attempts but fails to embrace his lover. He reads the moving lips of his reflected image and 'imagines a sympathetic response where there is none' (Anderson in Ovid 1997:384) and in that moment the truth of his mistake is realised. This moment of self-knowledge, as the seer had predicted, signals his death and Narcissus immediately begins to mourn his own end. We, along with Echo, watch as the gaping hole in his psyche is exposed. Still in soliloquy, Narcissus wishes he could create two selves from his one body so that mutual love could ensue. He consoles himself with the thought that death will end his suffering and that he and his beloved will die together, but this does not assuage his mounting distress. He beats his chest in an act of grief more commonly associated with women, but the subsequent sight of the welts on the chest of his reflected image is a mutilation that is too much to bear and Narcissus slowly melts, 'consumed by the fire inside him' (Ovid 2004:116). Ovid switches back to narration as Narcissus' body is liquefied (Nouvet 1991) and we are reminded that Echo too has watched over the death of Narcissus. Her anger shifted to pity as she echoed his final farewell to his reflected image by taking his own words to farewell him herself. Mourners prepared the pyre and Narcissus' anguished sisters cut their hair and beat their breasts but when they arrived to claim his body they found no corpse, just the flower which now shares his name.

Brenkman argues that the narrative of Echo and Narcissism is organised as two separate stories which are tied by a 'displaced parallelism' (1976:297) that sees both characters driven to their deaths when their amatory desires are unmet. Narcissus, in temporal delay, replays his meeting with Echo in his encounter with his reflected image to seemingly repeat the sequence of events she has traversed earlier as the lover whose desires are denied who subsequently pines to a death of sorts. Despite the similarities of their experience there are, however, notable discrepancies. Narcissus imagines hearing the response of his reflected image where Echo had earlier provided a real one and, perhaps most significantly, the outcomes of their deaths are different. Whereas Narcissus' death is a terminal point for his delusions, desires and his body, Brenkman (1976:308) argues that Echo does not simply die within the text but is transformed into a character that lives on in voice form. Moreover, he argues, in death Echo is transformed into a finer character that is superior to her bodily form. She survives death but disembodied and no longer driven by the corporeal desires that had

previously animated her flesh she is able to respond to the dying Narcissus with pity rather than desire. Brenkman (1976:308) contends that Ovid preserves the organising principles familiar within Western thought of *vox* (voice-consciousness), *corpus* (body) and *imago* (image) which enables Echo to transcend her body and to live on in her voice, whereas Narcissus' fate, which remains unwaveringly committed to the deception instated between his body and its reflected image, stands in crystalline contrast. Brenkman's (1976: 322) reading of the poem observes the way in which Ovid positions Narcissus, Echo, narrator and reader within the text. It is the reader who fills in what Narcissus imagines but does not hear, and the text itself positions the reader, along with Echo, as the witness to Narcissus' descent into madness. First we watch Echo, but later we watch with her, the perennially fascinated spectator to Narcissus' decline.

Hearing Echo

Despite being generally forgotten in the long shadow cast by Narcissus, there are several authors who have recognised within Echo particular qualities which underline the ethical problem in listening to, responding to, and, in the case of Spivak (1993) in particular, speaking for the other (see Brenkman 1976, Nouvet 1991, Berger 1996, Greenberg 1998, Petek 2008). Echo, they argue, does not simply repeat what Narcissus has said. Rather, she takes his words to craft an answer which he then fails to recognise as his own speech. Echo offers more than just an echo, she offers a response which acknowledges and witnesses the suffering of the other.

Greenberg (1998) draws an analogy between Ovid's Echo and the experience of witnessing, narrating and representing traumatic experience. With a view to exploring the potential which a close examination of Echo's interaction with Narcissus might offer, Greenberg observes a parallel between the structural similarities found in Echo's experience of trauma and those who suffer Post Traumatic Stress Disorders. The subsequent disembodiment and belated and fractured resonances of those who survive trauma are, she proposes, strikingly similar to Echo's experience. Greenberg argues that, in the end, it is the isolation and neglect, the absence of a response in the aftermath of their rejections, which precipitates the deaths of both Narcissus and Echo. Their deaths, she writes, illustrate 'the effects of *not* listening, of

failing to respond' (Greenberg 1998:332). In the interplay of their parallel stories it is Echo's capacity to maintain interactive dialogue which sustains her as a socially viable character, which stands in contrast to Narcissus' terminal self-absorption. Greenberg (1998:340) is primarily interested in the role ongoing narrative plays in addressing trauma and through the lens of Echo she proposes a shift from the analytic need to locate the "truth" of a traumatic event, to an acknowledgement of the continued need of those who suffer trauma to engage narrative processes which may, in turn, be witnessed and heard through interactive dialogue. Echo, she writes, symbolises such dialogue.

Through her repetitions of others' words, Echo assumes the role not only of the return of the trauma but the role of a listener who grants a survivor a responsive witness. Thus paradoxically, the return of an echo grants the recognition, the returning response, so longed for and unattained by Echo herself. In her final form (as pure disembodied echo), she manifests the transformation of a problem into a solution. The nymph's need for and absence of a response becomes endless, continued response for others. Echo's metamorphosis turns self-absorption, lack of dialogue, and trauma into a sense of dialogue and community, even in isolation (Greenberg 1998:331).

Although Greenberg's interest lies in the recovery from trauma, her suggestions might just as effectively be applied to hearing stories of shame which are collectively denied and, as a consequence, remain unheard and therefore hidden. Declining to hear stories of shame denies its presence and means there can be no response, leaving those who feel shame with limited options. They can amend their shame, if they have access to the resources and skills which are required. If not, shame persists and gradually effaces the self to render abjection a real possibility, an outcome the example of Narcissus makes very clear.

Narcissus and shame

Claire Nouvet (1991) also takes issue with the commonly held perception that Narcissus is self-absorbed. When he looks into the pool, she writes, Narcissus does not see himself, since he clearly makes an error and mistakes the image he sees for another. He is unable to tell the difference between *imago* and *corpus* or comprehend the mirror effect of water (Nouvet 1991:122). Like Echo in the previous scene, Narcissus falls in love with a desired other and his experience repeats hers as one characterised by unmet desire and rejected love. In view

of Lewis' (1971:17) claim that rejection in love induces shame, it is plausible to suggest that Narcissus, like Echo, does indeed suffer shame. Echo's shame in being cursed for her indiscretions with Jupiter, followed by her rejection by Narcissus, is clearly stated. Her subsequent withdrawal and embodied implosion signify her experience as profoundly shameful. Echo, in her corporeal form, clearly experiences shame, but Narcissus, in keeping with the thematic organisation of 'displaced parallelism' which Brenkman (1976) proposes, also appears to suffer shame, but it lies hidden behind his beauty and the façade of his brittle pride.

Narcissus' beauty frames his pre-cursed social interaction, and clearly influences those who seek his attention, but his beauty also influences the way in which we might think about him. There are inherent biases associated with the way in which we perceive beauty that disrupt the parallel between Echo and Narcissus' experience and occlude the possibility of recognising Narcissus' shame. One commentator, Dean Davis (2004), provides an example. He readily glosses over the fact that Narcissus' beauty might in any way be problematic to him. He writes: 'it is difficult to see where in the myth Narcissus is injured ... He is merely beautiful and in love with himself. He appears to us to be spoiled' (2005:143). Ruined beyond repair or over-indulged: either way, Narcissus is beyond the empathy of this particular author. Davis' inability to recognise that Narcissus' beauty might be problematic to him denies that his beauty is an immutable element which frames his social interaction. It also suggests that physical beauty is trivial, unimportant and does not impact people in both basic and complex ways.

Beauty and the distortions it instates between body and image take us back to that other myth discussed earlier in this study, the beauty myth, in which Wolf (1991) unveils the spurious primacy that occularcentrism manifests between the feminine body and its image. This may be readily acknowledged, but is upheld, nonetheless, in the notion that physical beauty is so desirable that it is generally taken as a given and beyond question. Physical beauty, always culturally defined, is highly desirable. Those who are beautiful are frequently admired and desired, but Ovid, while emphasising his beauty, describes Narcissus as an object of sexual desire constructed in the lascivious gaze of the other. It is his beauty alone that brings

Narcissus attention, attention which he appears to neither covet nor welcome. Despite the attention he attracts Narcissus is overwhelmingly alone and untouchable. He refuses to be touched by Echo and, post-curse, when he desires more than anything to touch his lover, ensuing failure culminates his despair. Nouvet (1991:113), in discussing his pre-cursed state, argues that Narcissus' refusal to respond to the sexual advances of others is not simply that he resists being touched by sexual contact but, more profoundly, his refusal represents the 'desire to remain untouchable.' She writes:

Narcissus is afraid of being "touched" by the other in a metaphorical as well as a literal sense of the word ... Pride, in other words, describes the peculiar predicament of a subject who can neither experience desire nor respond to desire because he undertakes to constitute himself as absolutely impervious to the other. This desire of impenetrability proceeds from fear. As the dialogue with Echo indeed demonstrates, Narcissus fears and shuns the approach of the other as a violent dispossession, a radical impoverishment, the scattering of an all-too fragile unity (Nouvet 1991:113).

Nouvet (1991:113) proposes that Narcissus' pride is forged in the belief that he can constitute himself as a separate self, uncontaminated by sexual otherness. This need, she contends, arises from his fear that any intimate engagement with another will result in the collapse of his identity and his loss of control, characteristics which readily apply to those who experience shame.

Child of rape

Along with rejection in love, rape stands as one of the most viscerally shaming of all violations (Lewis 1971, Morrison 1998). Spivak (1993:22), while conceding that 'demidivine violence as sexual violence ... does not offend the political economy of the gods,' cannot overlook the terms under which Narcissus was conceived. For Spivak (1993:25), Narcissus is a 'child of rape.' She chooses a woman, whose tribal mother was raped by a colonial Englishman and subsequently wishes that her life had been terminated by her mother at birth, as emblematic of the 'subaltern postcolonial.' Spivak nominates this, the death wish of the child conceived in rape, the moment of knowing ones' self, as the moment of Narcissus (1993:24). Self-knowledge inaugurates death. Narcissus seeks the love of

another but when he realises that the one whom he loves is him himself, self-love is not a welcome revelation but is an occasion for mourning and death. Rather than being consumed by self-love, it would appear the opposite is more accurate. Narcissus desires something which is impossible, since both the love of another and self-love are ultimately unattainable.

While it is not clear whether the rape of Liriope is merely a narrative device to introduce Narcissus, or whether it is more significant to the subsequent unfolding of events in the story, themes of sexual interaction and agency in the face of another's desire are present within and at the margins of the text. The metaphor of chastity is evoked in Ovid's (2004:112) description of the pool as unsullied by shepherds, goats or cattle; as virginal, 'its surface has never been ruffled by bird or beast or branch from rotting cypress.' Desolate pools deep in the forest are formulaic settings in which Ovid locates strange and violent events which include rape (Ovid 1997:381). At one point in his rising despair Narcissus calls to the surrounding trees and asks why he must suffer 'cruel love,' a term Anderson (in Ovid 1997:382) argues, used on this occasion, denotes rape. Anderson's (in Ovid 1997:372) observation that raped nymphs are commonplace throughout the landscape of the *Metamorphosis* runs counter to Curran's (1978:230) claim that nymphs had "'amorous propensities'" and did not normally get raped. There are over fifty rapes in the *Metamorphosis* (Curran 1978, Richlin 1992), varying from the incidental to the appallingly brutal, but Richlin (1992:159) argues that 'Content is never arbitrary or trivial; content is not an accident of the text but an essential.' Rape, she argues, plays a significant role in Ovid's writing and accompanies a range of dark and dire outcomes including 'twisted loves, macabre and bloody deaths, cruel gods, cataclysms of nature ... wars, and, of course, grotesque transformations' (Richlin 1992:162). Rape within the text is still rape, and in Ovid's universe rape in the opening scene predicts an ominous ending, which may explain why Liriope sought advice from the seer in the first place.

Narcissus' attributes are limited to his beauty, which attracts sexual advances to which he does not respond. In the collective focus upon his body as an object of desire, Narcissus appears both debased and shamed. His vision of himself is created by those who surround and admire him. Alone by the pool, detached from the gaze of the other, Narcissus

misrecognises himself and can only see what others see when they view him: a beautiful but unattainable youth, which generates within him their same despair of unmet desire.

Recognising that he himself is the one he seeks to love confirms what his unmet desire has already suggested: that he is unlovable, and in that moment of recognition Narcissus begins to mourn his own death. Ovid (2004) appears to be making a more salient point about the dehumanising consequences of objectification, a theme Wolf (1991) aligns with gender and expands upon in the *Beauty Myth*. From birth Narcissus has known nothing but the adoration of others and this has denied him any sense of selfhood beyond the image he projects. Away from his admirers Narcissus confronts the emptiness of his imposed idol status. He is a fantasy collectively constructed and nurtured by the desire of others. He finally realises that he is nothing but an imaginary construct and it is this final terrifying realisation, eclipsing any tangible notion of embodied selfhood, which finally engulfs him. Shamed by his birth and shamed by his beauty, self-recognition is his final undoing.

Benjamin Kilborne (2002) ponders the question of Narcissus' death and suggests that, in being captured by his own image, Narcissus loses a sense of himself as a bounded identity situated within a social context. Kilborne presumes, as I have in this study that it is through the psychosocial act of imagining ourselves in the eyes of others that we interpret and regulate ourselves as social beings. In accounting for his death, Kilborne (2002:95) suggests that Narcissus becomes 'lost because there is nobody else in whose eyes he can imagine himself.' Following Sartre, Kilborne emphasises that there is an important functional element in the self-correction which shame inaugurates in the self: 'it is shame that keeps us human by imposing upon us our dependency on others' (2002:95). Moreover, he adds, without the capacity to feel shame our fate would resemble that of Narcissus and we too would disappear into ourselves. Kilborne is right in the functional attribution he accords shame, but his contention that 'there is nobody else in whose eyes he can imagine himself' is not entirely correct, since Narcissus sees himself as the same beauty seen by others. In writing Narcissus as bereft of the capacity to feel shame Kilborne takes a position which reinscribes Narcissus as shameless. Such a view limits the capacity to think of shame and its relationship to narcissism as problems of self and other-love, problems which are not confined to Narcissus alone and could, if acknowledged, humanise his dilemma as one that

underlines the psychosocial experience and the challenges demanded of the social participant. After all it is the reflexive problem of self-recognition and the combined impossibility of self-love and other-love that converge to make the proposition of living untenable for the young Narcissus. Narcissus' predicament has sustained ongoing interest which has given rise to contemporary understandings of narcissism, but the role of shame in his death has not been adequately acknowledged.

The second metamorphosis of Narcissus

Paul Näcke (Ellis 1928) is usually credited with the introduction of the modern use of the term narcissism in 1899. Näcke was the superintendent of a German asylum whose interest in new scholarly work extended to summarising publications written in English for presentation in German periodicals. When reviewing an article by the British sexologist Havelock Ellis, 'Autoeroticism, a Psychological Study,' written in 1898, Näcke translated Ellis' 'Narcissus-like tendency' as '*Narcismus*' (Ellis 1928:356). In his article Ellis (1928:355) had invoked the mythical Narcissus to describe auto-eroticism as a tendency 'for the sexual emotions to be absorbed, and often entirely lost, in self-admiration.' In Ellis' estimation auto-eroticism was not a perversion. The example he presented described a woman who derived great pleasure from admiring herself to the extent that she was disinterested in the admiration of others. Ellis described her as 'perfectly healthy,' 'normal' and 'clever' (1904:137, 138) and generally considered auto-eroticism to be a 'normal state with morbid exaggerations' (Ellis 1928:356). Despite Narcissus' association with comparatively normal behaviour, the 'ism' newly appended to his name quickly associated him with perversions of the day: transvestitism, exhibitionism, fetishisms, homosexuality and masturbation. Since the 1920s 'narcissism' has conveyed meanings of 'morbid self-admiration or self-love' (Kilminster 2008:136).

Freud (1914) further developed the concept of narcissism in his introductory essay on the subject. He follows Näcke in his usage of the term and makes no mention of the youth Narcissus. Freud believed, as has been discussed in an earlier chapter, that some degree of narcissism was normal and, indeed, necessary for healthy self-esteem. Moreover, he clearly states that his intention in studying narcissism was motivated by an interest in understanding

narcissism as a normal occurrence. He writes: 'Once more, in order to arrive at what is normal and apparently so simple, we shall have to study the pathological and its distortions and exaggerations' (1957:39). Freud described narcissism as an instinct of self-preservation which could 'justifiably be attributed to every living creature' (1957:31), but the clearest distinction made was between primary and secondary narcissism. He viewed primary narcissism as a normal, transitional, developmental stage that occurs when the infant chooses itself as a love object. Narcissism arises when the love, and I would add care, provided by others is withdrawn and the self is required to fulfill those needs. Separation, therefore, is directly implicated in the manifestation of narcissism. Secondary narcissism, which Freud considered to be pathological, occurs when the libido is redirected from relationships external to the self back toward the self in a manner which exceeds what could be considered normal. A normal experience of narcissism is encapsulated in the simple proposition of suffering, when the ailments of one's bodily or psychic phenomena render one incapable of loving another. Such an event might be transitory, as in the case of illness, when 'the sick man withdraws his libidinal cathexes back upon his own ego, and sends them forth again when he recovers' (Freud 1957:39). Some of the other comments Freud made, such as those suggesting that beautiful women and cats are particularly prone to narcissism, are neither substantiated nor helpful. At best they are ponderings which mistake the independence that beautiful women accrue as a result of the enhanced social capital their beauty may afford them. Alternatively, any perceived pride might easily be misread as a defence against the very same over-exposure that beset Narcissus himself.

Kilminster (2008:136) points out that Freud's successors have modified aspects of his theory towards an explanation of narcissism that is 'related to the ways in which individuals cope with themselves and their relationships with others.' Writing in 1939, the psychoanalyst Karen Horney (discussed in Kilminster 2008:136) made a distinction between the self-love related to self-esteem and the unrealistic 'self-inflation' evident in pathological or secondary narcissism. Kilminster agrees that normal aspects of narcissism have been eclipsed by connotations of negativity and suggests that this is in part because of the way narcissism has been interpreted across a range of disciplines including the fine arts, literature, philosophy, and in social criticism. Narcissism entered the mainstream vocabulary in the 1970s when

- social scientists appropriated it as a term to describe and diagnose a diseased culture consumed by self-absorption. Catt (2002:391, 394, 395) proposes that through the work of social scientists narcissism has become naturalised and normalised as a concept to describe social phenomena. He nominates the social historian Christopher Lasch (1978) and the sociologist Richard Sennett (1977, 1997) as contributors to that process.

Social scientists have engaged the concept of narcissism on limited occasions but, while their impact has been considerable, particularly in the case of Lasch (1978), they have tended to view narcissism in ways that have supported its conceptualisation as pathology and have not taken the opportunity to reconceptualise narcissism as a normative behaviour which might be explored in much more sociologically relevant ways. The sociologist Richard Sennett (1974, 1997) and social historian Lasch (1978) used the concept of narcissism, heavily invested with pathological connotation, to diagnose the self-interest of whole populations. Both overlook any link between shame and narcissism. In *The Fall of Public Man* Sennett (1974) interprets the self-absorption of narcissism as the notional tendency to confuse the boundaries between self and society. He argues that narcissistic absorption with the self has arisen because modern society 'encourages the growth of its psychic components and erases a sense of meaningful social encounter outside its terms, outside the boundaries of the single self, in public' (1974:8). Sennett describes the modern self afflicted with narcissistic tendencies as introverted and trapped in introspective questions which seek to authenticate self-experience at the expense of broader and more noble causes like participation in social life.

Culture of narcissism

Lasch upholds similar sentiments in *The Culture of Narcissism: American Life in an Age of Diminishing Expectations* (1978), a book which Shilling (1993:194) describes as unremittingly bleak. It is difficult not to agree with Shilling's appraisal as Lasch displays little optimism for future social life in the hands of a generation he describes as highly narcissistic. Lasch writes of a 'dying culture' now adrift from the patriarchal structures that once anchored and guided it, of a society disinterested in its past, facing a future devoid of hope and inescapably locked into the present, while consumed by narcissistic preoccupations of the self. He believes the phenomenon of self-interest in contemporary American society

has arisen from a particular set of social and cultural movements that have created within individuals rising angst and an amplification in narcissistic tendencies. Rampant consumption, increasing bureaucratisation, the ascendancy of visual culture, changed patterns of socialisation which include the outsourcing of parenting, the decline of religion, and the proliferation of therapeutic sensibilities are all put forward as factors contributing to the rise in narcissism (Lasch 1978:32). The progressive erosion of the capacities which individuals once possessed to manage their own productive and reproductive lives has resulted in a reliance on bureaucracies and governments to manage what were once everyday competencies. Contemporary narcissism, Lasch argues, is a psychological manifestation of sanctioned dependence (1978:10). In Lewis' (1971) formulation dependency in any form is potentially shaming, but Lasch himself does not make such a link.

Lasch (1978) identifies the changes that have encouraged narcissistic tendencies by drawing attention to particular technologies which promote self-surveillance: mirrors, cameras and video recordings, which are in turn supported by therapies that encourage and normalise self-scrutiny. This shift to introspection and self-examination is set against the global context of a doomed planet in which the overarching concern is survival. In the face of apocalyptic threats external to the self - impending nuclear war, economic crises and, I am sure if he were writing today, global warming - Lasch describes narcissism as a retreat from politics to the sanctuary of psychic and self-improvement. A fear of impending desolation, which is perceived as overwhelming and beyond the control of the individual, has created within the self a desire to live in the immediacy of the moment. An ethic of self-preservation drives the self consumed by an anxiety born of the social chaos and eroded hope which modern society has produced (Lasch 1978:51). Whereas religion may have once assuaged personal anxieties with promises of salvation, contemporary societies have sought relief within the proliferating range of therapies that readily promise enhanced well-being and psychic security. These therapies do not challenge old ideologies and, if anything, merge with the perennial American belief which proclaims the personal power of the individual to determine his or her own fate. Modern therapies flourish in the spiritual vacuum once occupied by religion. They palliate rising feelings of emptiness and social isolation while validating endless preoccupation with the self.

Lasch views narcissism in a particularly negative way in part because he interprets the contemporary character traits proliferating across society as manifestations of pathological narcissism. In a methodologically dubious manoeuvre Lasch (1978:38) looks to clinical descriptions of narcissism and extrapolates that the “pathological narcissism” found in character disorders ... should tell us something about narcissism as a social phenomena.’ The tenor in Lasch’s writing never quite loses its tone of condemnation, but whether Lasch goes beyond passionate oration and actually substantiates his tacit claim that society is becoming increasingly narcissistic is questioned by Kilminster (2008). Kilminster argues that Lasch’s thesis relies heavily on ‘rhetorical persuasion,’ which is informed more by his contempt for the ‘informalization’ of society that occurred during the 1960s and less on empirical evidence to substantiate his claims. Kilminster (2008:138) describes Lasch’s diagnosis of society as a ‘nostalgic lament’ for the passing of a time when class structure clearly marked out social division, and he argues that Lasch’s generalisation from pathological condition to social diagnosis is ‘essentially ... an ideological description of what he intensely dislikes about society written in such a way as to try and convince readers to see it as he does’ (Kilminster 2008:140). These observations aside, there can be little doubt that Lasch’s concerns did touch upon a nerve as he has been widely read and his thesis continues to generate discussion.

Lasch’s (1978) view of narcissism as unreservedly pathological excludes any possibility of understanding narcissism as normative behaviour. Although he associates narcissism with the particular anxieties associated with dependence and the engulfing feeling of lost control, characteristics also associated with the manifestation of shame, Lasch makes no connection between narcissism and shame. In many ways Lasch’s ‘rhetorical persuasion’ (Kilminster 2008) attempts to shame those he deems narcissistic in the same way that Lewis (1987b:101) suggests Kernberg and Kohut do in diagnosing their patients as narcissistic. It is perhaps no coincidence that Lasch draws his clinical examples from Kernburg and Kohut’s work. In Lasch’s view narcissism is ‘other,’ something despicable, an insult, something not named as shame, but his intention appears to be to induce shame. Like Ovid’s chronicle of the ill-fated youth, Lasch assumes the role of storyteller to prophesise another death in the name of Narcissus, but in his case it is the death of an entire culture. Perhaps Lasch would have been

well served if he had referred to Ovid, as he may have identified something more positive within Ovid's formulation of Echo and her lesson of empathy. Empathy is what mirroring the other teaches us. It is what Narcissus, so overwhelmed by his own shame, fails to comprehend. His experience can be directly contrasted to Echo's: she transcends her body, her shame and her anger to bear witness to Narcissus' death. The pity she feels might partly be for her own loss but it does extend to Narcissus in a nascent form of empathy. Empathy lies at the very heart of what it means to be social; it is an adhesive which binds the members of social groups together. It is indispensable to any manifestation of society and it is a capacity which the pathological narcissist completely lacks. The pathological narcissist, consumed by overwhelming self-loathing, is locked in to administering compensatory self-love. Self-concern excludes countenancing the views, feelings or attitudes of another. Pathological narcissism is a state of self-orientation which is, in and of itself, antithetical to the very notion of a society.

Although largely responsible for diagnosing the pathological narcissist, psychologists it would seem, have not reached consensus in defining narcissism. An edition of the journal *Psychological Inquiry* (2001) was dedicated to a discussion of narcissism and it provides ample evidence to suggest that the opinions of psychologists regarding what constitutes narcissism are far from conclusive. One commentator claimed that narcissism has become such a loaded and negative term that psychologists are skewed in how they view and treat the patients they diagnose as narcissistic. He wrote:

Narcissists are seen as fragile, empty, or having foundations of "quicksand." I suspect that our goal in understanding narcissism in normal populations is impeded by this view, and that our research may be best served by moving to a more positive view of the construct (Campbell 2001:214).

Campbell (2001:214) believes the common view of narcissism assumes that it is an implicitly negative trait, which obscures the possibility of understanding that 'narcissism may be a functional and healthy strategy for dealing with the modern world.' He calls for a more positive conceptualisation of narcissism and a return to Freud's formative proposition that

narcissism be understood as the embodiment of the survival instinct which is implicated in the self's preservation (Campbell 2001:215).

Stolorow (1986), writing from a psychoanalytical viewpoint, also views the role of narcissism as functional. In a well-organised essay he proposes that understanding the functional role of narcissism will contribute to eliminating the ambiguity surrounding it. In a move that is welcome Stolorow identifies four different forms of narcissism. The first accounts for narcissism as a perversion, the second as a mode of relating to objects (in psychoanalytic terms this includes relationships), the third form of narcissism is nominated as a developmental stage and the fourth form of narcissism concerns the management of self-esteem. It is this last category which is of interest here. Narcissism, Stolorow contends, functions to regulate self-esteem 'and to maintain the cohesiveness and stability of ... self-representation' (1986:205). He likens the relationship between narcissism and self-esteem to the function of a thermostat which kicks in automatically to regulate room temperature. When 'self-esteem is threatened, significantly lowered, or destroyed,' as may occur in the event of encountering shame, 'then narcissistic activities are called into play in an effort to protect, restore, repair and stabilise it' (Stolorow 1986:205). Stolorow himself makes no mention of shame, but his observations relating self-esteem and narcissism support findings in this study which suggest that in constructing and reconstructing its identity in response to events that are shaming, the self oscillates between evaluation and amendment, between shame and narcissism in assessing and correcting its social performance. If Stolorow's proposition is correct, narcissism might be viewed as a normal response, automatically kicking in to amend any shame that threatens self-esteem.

Findings from this study support Stolorow's contention that narcissism is initiated in response to threatened self-esteem. Many participants underwent cosmetic surgery at a time when their self-esteem was low. Poor body image and the subsequent shame it induces combine in a potent force that effaces self-esteem. Findings from this study suggest that shame is a precursor to narcissism. The self, in the event of acknowledging its own shame, mobilises narcissism as a strategy to amend its shamed status and to restore self-esteem in a similar manner to that which Stolorow (1986:205) proposes. Moreover, Stolorow (1986:206)

makes another centrally important point when he proposes that narcissism should be assessed as either unhealthy or healthy depending on how successfully it functions in restoring and repairing self-esteem. In view of the increasing evidence suggesting that cosmetic surgery is addictive, as was observed in this study and others (see Blum 2003), its efficacy in repairing poor self-esteem over the long term is yet to be confirmed.

Narcissism, shame and poor body image

The findings of this study suggest that cosmetic surgery is enacted to resolve a breach between the self and its poor body image. Furthermore, those who sought cosmetic surgery frequently described enduring histories of poor body image. Just over half of those participating in this study identified their growing body image dissatisfaction as a form of self-consciousness directed towards their appearance, which had begun in childhood or adolescence. In many instances their impressions had emerged from a perception that their appearance, or an aspect of their appearance, had failed to meet a standard that was valued by one or more significant others. In agreement with Lewis' (1971) basic formulation of shame, I have argued that accepting and internalising another's poor evaluation of one's self is an expression of shame. Significantly, shame only arises when the credibility of another's critical view of the self is embraced. Exposure of the self is intrinsic to the shame experience and, while this exposure may occur in public, the crucial shift which transpires within the shame experience occurs privately when the self's flaws are exposed to, and acknowledged by the self. Shame is a private experience which concerns the self and its perceived shortcomings, but the parameters of shame and its designations are prescribed within the social world.

Shame, it will be recalled, implicates the whole self. Poor body image, which this study found to be shame-inducing, readily conflates with self-perception to pervade the entire self with shame. Throughout the course of this study it has been suggested that those who initiate cosmetic surgery do so as a self-improvement measure to resolve poor body image. However, when poor body image is recognised as shame-inducing, the amendments which the self seeks through cosmetic surgery extend beyond transforming poor body image to amending the self-loathing that poor body image generates. This study observed that poor

body image readily suffuses the self-concept of those who are vulnerable to shame and, in such instances the self, convinced of its unattractive exterior and subsequent unworthiness, withdraws from social life to conceal its shamed state. From its position of self-imposed exile the shamed self, through the medium of body image, plans its own amendment. The process of amending shame through the surgical ritual replicates the classic sequence of the 'life crisis rituals' outlined by van Gennep (in Turner 1982:24), who identified the rituals accompanying changes in social status as processes characterised by three phases: separation, transition and incorporation. Participants appropriated cosmetic surgery as a technology of transition, or better, transformation, to amend their perceived flaws and fulfil the final part of what might be considered a shame sequence, the culmination of which was the successful restoration and incorporation of the amended self within their social world.

Those participating in this study who did not describe complex histories of poor body image also experienced their pre-surgical bodies as flawed and utilised cosmetic surgery as a pre-emptive or contingent measure to manage potential shame. Cosmetic surgery as a form of grooming ritual was deployed to manage the body's exterior, and those who undertook cosmetic surgery sought to avert or amend poor body image with a view to preserving or enhancing social status. The most highly desired outcome of cosmetic surgery was simply expressed as the desire to be content with one's body image but, within the psychosocial dynamic of shame, self-love is also a metaphor for being loved by another. Shame and the narcissism employed to resolve it, while often deemed intrapsychic phenomena, arise at the interface between the self's psychic and social experience. Together shame and narcissism constitute reactive processes which are initiated in response to perceived social phenomena. Shame and narcissism emerge as integral to the corporeal labour the self engages to negotiate, construct and reconstruct its social identity. An awareness of shame structures and the desire to amend or protect one's self-esteem against potential shame, by initiating narcissistic measures, frames this engagement.

The body and shame

The increased emphasis on personal grooming is directly implicated in the shift to the observational mode which Elias (1978:78) identified as inaugurating the rise in the anxiety

surrounding the body increasingly burdened by shame. The body and the bodies of women in particular, with their evident link to nature, are imbued with shame that many centuries of evolving etiquette regimes have aspired to discipline (Elias 1978). At the level of the body, shame is directly implicated in the control of its margins and grooming measures are the learned stratagem within which the materiality of body is managed. The evident growth in grooming industries attests to the concern and labour which individuals direct towards their body's appearance. Grooming behaviours accord the body a central focus in managing body image and self-esteem and, consequently, enhancing or maintaining social status. Within the visual orientation of modern society, being seen by others as socially valid is an important component of social status, particularly for women.

It is through the learned art of grooming practises that we acquire the knowledge required to become socially embodied. Grooming is directly implicated in managing the shame and potential shame associated with the body. Grooming the body commonly precedes social interaction. When preparing and rehearsing the transition from private to social self, the self engages its reflection to evaluate its appearance and any amendments deemed necessary are addressed through personal grooming. Initially appalled by their reflected images, the women in this study mobilised imaginary knives to carve out something on the body's surface that the self could then love. Subsequent surgeries were, first and foremost, engaged to restore self-love and through self-love, the love and approval of others. In this study cosmetic surgery represented a narcissistic strategy to correct the shame associated with poor body image, but any grooming strategy directed to amend the shame or potential shame of the body, could likewise be considered a normative form of narcissism.

A search for academic literature specifically related to "grooming" produced remarkably few results. I can only speculate that the notion of grooming veers too close to the animalistic truth of the human body which humans have gone to considerable lengths to deny (Elias 1978). One article, written by the physician and academic Y. Michael Barilan (2002:240), defined grooming as activities directed towards the body to produce a positive outcome, be they medicinal, aesthetic, erotic, or cultural. Broader definitions of grooming extend to the cultivation of other people with a view to benefiting or enhancing the self, as in the case of a

sexual predator who grooms a potential victim, or a leader who mentors a lower ranked employee with a view to future succession, but it is grooming at the level of the body which is of interest to the present discussion. Bodily grooming is, in part, essential to the comfort, functionality and integrity of the body. It also encompasses pleasurable activities which excite and please the senses. Through grooming activities individuals address and manage the materiality of their bodies at personal and social levels. Bodily grooming engages creative processes to which sophisticated, semiotic understandings are attached and to which competent individuals are held accountable. Rules designating how the body is groomed are overlain by social requirement and cultural constraint. Grooming, either indirectly or directly, enhances the self.

The body is the ultimate site of ritual and display, and history has seen fashion and, more recently health concerns play a vital role in defining what constitutes desirable female appearance. Modern cosmetic surgery provides an example of the commercialisation of grooming practises but it maintains an increasingly dubious legitimacy as a medical specialty. It has mounted its commercial trajectory from the cleft between fashion and medicine, as a technology tailored to answer the increasing discontent at the heart of body image anxiety. From its privileged position, the cosmetic surgery industry is progressively medicalising appearance by defining the physiological parameters of “normal” within the context of what can be surgically manipulated. Its agenda promotes body image anxiety while proffering surgical remedies to correct an ever increasing catalogue of recently defined physiological anomalies. Moreover, the list appears to grow as surgeries are devised to discipline unruly, feminine flesh.

Participant accounts suggest that inhabiting a body which is viewed as deviant is experienced as something shameful and deeply private. Despite the increasing normalisation of cosmetic surgery, evidence from this study suggests that seeking surgical amendment remains very much a private affair. Participants minimised the risks associated with cosmetic surgery to generally view it as a positive means of ameliorating a despised aspect of their appearance. At the very least, cosmetic surgery was sought to reconcile the tension between a loathed body image and the poor self-esteem that shame initiates within the self. The divisiveness

and disunity evidenced within such a rift was described, in the most complex of accounts in this study, as the rupture between an alienated self and the broader social group. Framed in such a way, cosmetic surgery was viewed by participants as a necessary step towards social re-engagement.

Whether surgical amendment alone can deliver on the expectation of self and social restoration is, of course, contentious. Investing in one's physical appearance to salvage a sense of self is a risky strategy. The success of a cosmetic surgical outcome depends on the subjective perception of success and, because the underlying reasons for seeking cosmetic surgery frequently implicates shame, cosmetic surgery alone is an unlikely panacea for those who seek its modifications. However, the lure of endless incremental improvement through cosmetic enhancement can be deeply seductive in compelling consumers to re-present to surgeons over and over again in the quest to achieve an illusive notion of physiological perfection which may mask deeper and more complex problems. Adding to concern that cosmetic surgery may gloss over the deeper troubles confronting the women who seek it, is the more general problem of the regulatory discourse around body image that cosmetic surgery generates. Cosmetic surgeons and their supporters create narratives which contend that those who undertake surgical enhancement are merely exercising a consumptive choice, but such a view does not account for the way in which cosmetic surgeons are redefining and limiting the parameters of the female body while contributing to the growing angst that women feel towards their appearance. It is, after all, in the interests of cosmetic surgeons and the profession they represent to encourage all women to reassess their body images through their critical lens as faulty and in need of surgical amendment. As a consequence cosmetic surgery potentially shames all women.

For women, social capital and physical capital have long been conceptually and materially intertwined. An unyielding value placed on the importance of physical appearance, and the persistence of this legacy, makes women highly susceptible to appearance anxiety in ways that men have not traditionally been vulnerable. Poor body image is a manifestation of the wider social significance placed on the appearance of women and the oppressive value system which surrounds it. The shaming effects of poor body image encourage private

behaviours and personal anxieties which conceal its materiality. Concerns about body image reduce participation in social life while increasing the inclination to hide aspects of the self. Those with poor body image experience social life on the periphery, or fear banishment to its margins, and it is from this extremity that the self justifies any remedial measures undertaken. Participants argued that restoring body image was required to reinstate self and social acceptability. Undertaking cosmetic surgery is a self-improvement measure, but it is also driven by the need to pre-emptively protect social status by guarding against the potential shame of becoming socially irrelevant, and it is within this context of amending self-acceptability that the self rationalises the undertaking of cosmetic surgery as reasonable. This may, in some part, account for the very different explanations which the participants themselves gave for undertaking cosmetic surgery in comparison to those who stand on the other side of the debate and are critical of those who seek its fixes. Hearing stories of shame will never be easy because it involves confronting aspects of the self which most people would rather not concede, but there is in Ovid's *Echo* a model for hearing shame. It requires firstly an acknowledgement of the persistent vulnerability to the notion of a cohesive self that appearance regimes present to all women. The stakes in this discussion are high because, in declining to hear the accounts of those who engage in practises such as cosmetic surgery with some degree of empathy, social scientists risk becoming unwitting accomplices in masking, and consequently dismissing, the privatised shame underpinning the body image anxiety to which many women are vulnerable.

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Appendix



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Reflecting Upon Cosmetic Surgery
Jane Northrop (Researcher)
Information Sheet.

My name is Jane Northrop and I am researching people's experiences of cosmetic surgery. Cosmetic surgery has become increasingly accessible, but little is understood about the experiences of those who undergo such surgeries. I hope to learn what shapes people's decision making to have cosmetic surgery and the ways in which this type of surgery impacts upon the lives of those who undertake it. Participating in this research provides an opportunity for people to tell their own stories, while remaining anonymous, and to contribute to wider understandings of cosmetic surgery. If you are interested in participating please contact me by phone (6223 8200) or email as listed below.

Research participants invited to take part in this project are those planning to undertake cosmetic surgery in the near future, or those who have elected to undertake cosmetic surgery or procedures within the last ten years. Medical practitioners and beauty therapists have been asked to assist in this research by distributing this information sheet to potential participants. Participation in this project is voluntary, and any details identifying you as an individual will be changed to ensure that you are not identifiable in any output of the research.

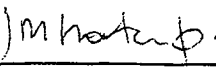
Participating in this study will involve taking part in an informal, conversational interview lasting approximately one hour in length. For those planning to undertake surgery, up to two follow-up interviews of a similar length, may be requested after surgery. Interview themes will focus on issues such as physical appearance; how surgery came to be viewed as an option; who was supportive in making the decision to proceed with surgery and the ways in which physical change has impacted upon your experiences. Personal information will be discussed, and if this has the unintended consequence of causing distress, counselling is available free of charge. You can refuse to answer any question(s) you are not comfortable with and you can withdraw from the interview and study at any time. In the event of this happening, you may direct that any information or data you have supplied to date be withdrawn from the research.

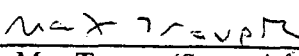
All interviews will be audio taped and later transcribed. You can read the transcript of your interview and edit, modify or withdraw any material if you choose. Data gathered in this study will be kept for five years from the time the project is completed in locked files within the School of Sociology, Social Work and Tourism, after which it will be destroyed by the use of a magnetic wiper to erase audio- tapes, and transcripts shredded.

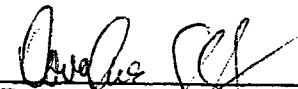
A final summary of the results of the study will be provided to participants who request it. Your contact details will only be kept if you would like a copy of this summary forwarded to you; to view your interview transcript; or if you agree to further interviews. Contact details will be kept separate from, and not linked to, audio-tapes or transcriptions to ensure your name is not linked to the research.

This research will form part of a doctorate I am undertaking through the School of Sociology, Social Work and Tourism at the University of Tasmania. Doctors Max Travers (6226 2750) and Douglas Ezzy (6226 2330), of the aforementioned faculty, are supervising the project and may be contacted if further information is required.

The Human Research Ethics Committee (Tasmania) Network has approved this study and if you have any concerns or complaints of an ethical nature you may contact the Executive Officer, Ms Amanda McAully on 6226 2763. You will be asked to sign a consent form to evidence your willingness to participate in this research, and you will be provided with a copy of this information sheet and the consent form to keep.


Jane Northrop (Researcher)
(janen@postoffice.utas.edu.au)
Phone 6223 8200


Dr Max Travers (Supervisor)
(Max.Travers@utas.edu.au)
Phone 6226 2750


Dr Douglas Ezzy (Supervisor)
(Douglas.Ezzy@utas.edu.au)
Phone 6226 2330

Private Bag 17 Hobart
Tasmania Australia 7001
Telephone (03) 6226 2186
Facsimile (03) 6226 2279